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WORLD CONGRESS OF CATHOLIC HOSPITALS AND HEALTH CARE INSTITUTIONS

PROCEEDINGS

CONFOEDERATIO INTERNATIONALIS
CATHOLICORUM HOSPITALIUM

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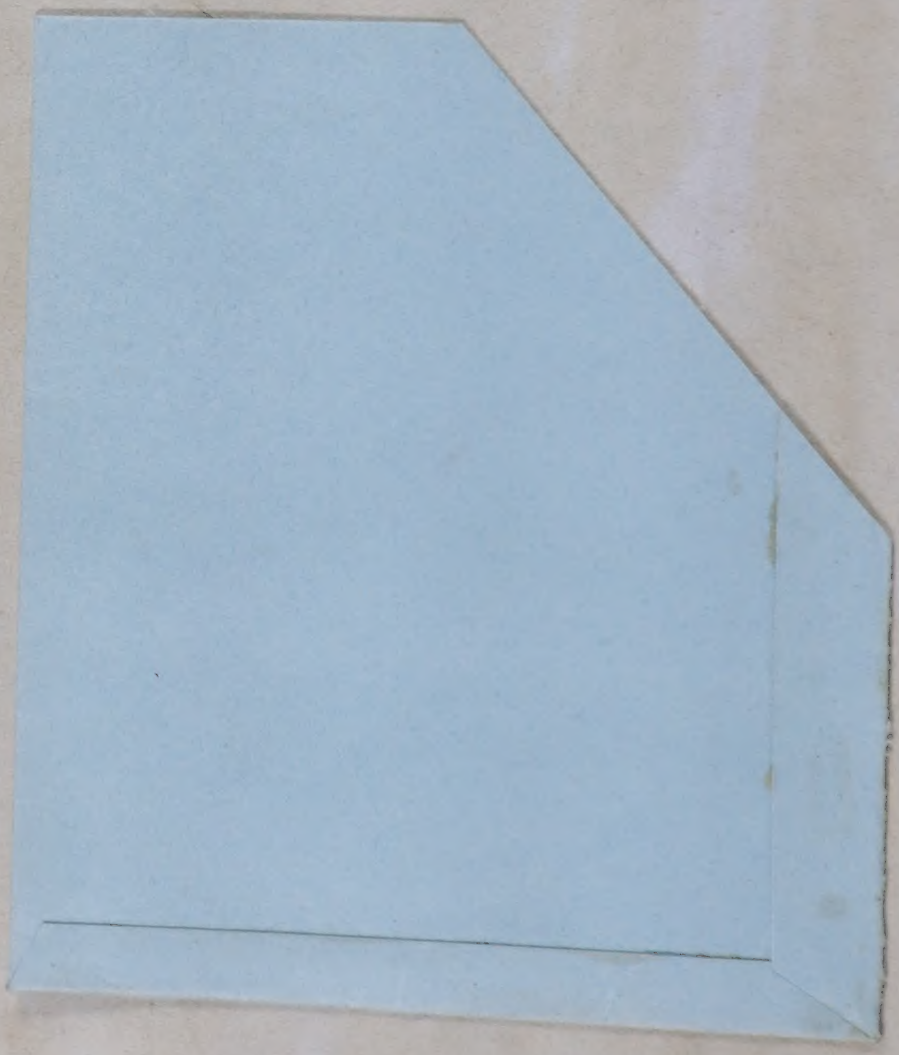

ALLOCUTION OF HIS HOLINESS JOHN PAUL II TO THE FIRST WORLD CONGRESS OF CATHOLIC HOSPITALS AND HEALTH CARE INSTITUTIONS

Dear Brothers and Sisters,

1. I am truly happy to receive in a special audience all of you doctors, nurses, volunteers, nursing sisters and administrators who, representing Catholic Hospitals throughout the world, have gathered in Rome for your Congress. Your aim is not only to study more deeply ways of improving collaboration between hospital health structures, but also to provide scientific and technical support, as well as practical assistance, especially to developing countries.

I extend cordial greetings to all present, and particularly to the promoters of the "Confoederatio Internationalis Catholicorum Hospitalium": to Monsignor James Cassidy and to Dr. Marcello Sacchetti, respectively President and Secretary General of the Promotional Committee. A special greeting also goes to the esteemed Monsignor Fiorenzo Angelini, Pro-President of the Pontifical Commission for Health Workers, and to Brother Pier Luigi Marchesi, who is here representing the Hospital Religious Institutes.

I wish you to know how pleased I am at your initiative, one which I hold to be important because it brings together qualified workers in the delicate field of health care in a context of knowledge, of friendship, of discussion, providing you with a stimulus and a source of encouragement in the often exhausting and anonymous exercise of your activities. I am certain that your meetings, aimed at promoting ever closer cultural exchange and technical collaboration, will

prove useful to your profession and for better service to those who turn to you for health care. It was, precisely to increase such cooperation that I instituted a special Pontifical Commission last 11 February expressing in the Motu Proprio *Dolentium Hominum* my hopes for a better coordination of all the Catholic organisations involved in the health care field.

2. When it is a question of organisations like yours, which are inspired by the Gospel of Christ and the Magisterium of the Church—which by innate vocation has always promoted the care of the sick—my words become ever more confident and I feel more deeply grateful for the work that you perform. Your character as Catholic health care workers, who find in Christian moral principles a stimulus for your mission, makes you in some way continuers of the Lord's healing activity, summarised in this way by the Evangelist Matthew: "He went about all Galilee, teaching in their synagogues and preaching the gospel of the kingdom and healing every disease and every infirmity among the people. So his fame spread throughout all Syria, and they brought him all the sick, those afflicted with various diseases and pains, demoniacs, epileptics, and paralytics, and he healed them" (*Mt* 4:23-24).

As is well known, the cures worked by Jesus were not reducible to the pure and simple elimination of a pathological condition, but were at the same time prophetic signs of the advent of the Kingdom of God and of the new spiritual situation brought about in the one healed. In the biblical conception illness, like exile and slavery, appears as a provisional reality whose disappearance is tied to the coming of a new era. When Jesus healed the man born blind, the disciples asked him: "Rabbi, who sinned, this man or his parents, that he was born blind?" Jesus responded: "It was not that this man sinned, or his parents, but that the works of God might be made manifest in him" (*Jn* 9:2-3). Cures were thus the occasion for restoring physical health and for granting the soul salvation—for establishing, that is, the Kingdom of God in the one healed.

From Jesus' example the Catholic health care worker derives the duty not to limit himself to the care of the body, though this is always urgent and necessary, but to extend his concerns to the evangelisation of the soul, inasmuch as patients have the right to be instructed on the meaning of life and death in the light of the Christian faith. Rich in this spirituality, the health care worker, particularly the priest, with the pastoral council, is called to carry on an important activity among the sick and their families, an activity founded on Christian hope. Beloved brothers and sisters, be credible and attentive witnesses of this hope at the bedsides of those who look to you for relief of the body and comfort of the soul.

3. In a world which is rapidly being transformed, you have also come together to exchange views concerning the technical aspects necessary for a better functioning of your health care facilities. In order to realise the lofty ideals I have just mentioned, Catholic Hospitals must neglect nothing in their efforts to assist the sick in the manner required by their dignity as persons "made in the image and likeness of God" (*Gen* 1:26).

No one is unaware of the way in which technological evolution and social, economic and political changes have altered the foundation upon which the whole life of the hospital rests in today's world. Here we see the need for new dimensions in the educational process, especially in technical training, but above all in the moral preparation of health care workers at all levels.

Since Catholic Hospitals are called to witness to the Church, they must re-examine in depth their organisation, making sure that it ever better reflects the gospel values echoed in the social and moral directives of the Magisterium. May they not let themselves be absorbed by the "systems" that aim only at the financial component and the clinical-pathological aspects. May they be capable of drawing ever nearer to man and of assisting him before the anxieties which assail him in the most critical moments of illness.

May they be capable of creating a culture directed towards humanising medicine and the hospital environment.

All this requires a strong unitary movement among Catholic Hospitals—in all sectors, including the financial-organisational one. With this hoped-for unity, Catholic Hospitals, even more than any other hospital institution, must be open to the needs of all patients on every continent, especially in developing countries.

4. There is one specific form of service that I would like to suggest once more for your consideration, for in this matter too, I am convinced that Catholic Hospitals ought to be an example to other services and structures. In every part of the world there is a vigorous increase in the phenomenon of voluntary service, whereby large numbers of people, especially among the young, offer to spend at least a part of their time in doing unpaid work for the community. For Christians, assuming such responsibility for the public good is a practical way of showing a willingess to follow Christ's example by sharing the problems and difficulties of one's brothers and sisters.

How can we fail to give due recognition to the significant contribution that can be made to health care facilities by the loving and discreet presence of voluntary workers, complementing the work of the nursing staff? Voluntary service, if it is properly coordinated, can help to improve the quality of the care provided, adding an extra touch of human warmth and attention which can obviously comfort the patients and probably also have a positive effect on the course of therapy.

I know that in a considerable number of Catholic Hospitals, especially in the chronic wards, much is already being done in this sphere. But present circumstances would seem to suggest that now is the time for an effort to make even greater use of the resources of generosity available in the community, and for this purpose it might prove very useful for the various hospitals run on Christian lines to share their experiences. The objective to be aimed at is a health care structure that is not isolated but a vital part

of the social fabric of the neighbourhood. An active exchange between the community of the healthy and the community of the sick cannot fail to prove a powerful incentive to a general growth in charity.

The present moment is full of great responsibilities for Catholic Hospitals, and their survival depends upon how Catholics succeed in dealing not only with the sick of today but with all the people of today. Their survival likewise depends upon whether Catholics will succeed in creating a new culture and new forms of pastoral care for the sick, capable of witnessing to Christ as the Saviour of both soul and body.

5. Dear brothers and sisters, the problems awaiting a solution are very many. My hope is that you will not fall short of what is expected of you in order to maintain the high esteem rightly accorded to the health care institutions which the past has entrusted to your responsibility. Continue to follow your traditions with exemplary dedication, for the cause which you serve is notable and ennobling: it is the cause of humanity! May this ideal sustain you in the difficulties that you encounter and may it inspire in your hearts the sentiments that caused the Good Samaritan to take care of the man left wounded on the road (cf. *Lk* 10:30-35).

To all of you I impart my Apostolic Blessing.

OPENING OF THE PROCEEDINGS

His Eminence Cardinal E. PIRONIO
President of the Pontifical Council for the Laity and the Pontifical Commission for the Apostolate of Health Care Workers

A PASSAGE FROM THE GOSPEL OF ST. MATTHEW

My friends, I intend to open the proceedings at this very important gathering of delegates of Catholic Hospitals with a prayer. Let us first read a passage from the Gospels and then, after a few moments of silence, let us call upon the Light of the Spirit and the maternal protection of Mary. The passage is taken from the Gospel of St. Matthew, chapter 25: "Then the King will say to those on his right hand, 'Come, you whom my Father has blessed, take for your heritage the kingdom prepared for you since the foundation of the world, for I was hungry and you gave me food, I was thirsty and you gave me drink, I was a stranger and you made me welcome, naked and you clothed me, sick and you visited me, in prison and you came to see me'. Then the virtuous will say to him in reply, 'Lord, when did we see you hungry and feed you, or thirsty and give you drink, when did we see you a stranger and make you welcome, naked and clothe you, sick or in prison and go to see you?' And the King will answer, 'I tell you solemnly, in so far as you did this to one of the least of these brothers of mine, you did it to me' ".

Let us meditate for a few moments in silence on these words of our Lord.

"Lord Jesus, Thou art amongst us this morning. We are beginning our labours in Thy name. Lord, Thou wilt one

The same basic question had been asked to all the representatives of the various continents: What is a Catholic Hospital? In answering, the speakers elaborated on the following themes:

1. A brief description of the health care system adopted in the speaker's own continent.

2. The number and functions of Catholic Hospitals and primary health care services. Description of the organisations existing in each country.

3. The fundamental aspects of the health care system.

4. The present forms of aid:
— the role of government;
— the role of the organisation of health insurance;
— the role of the ecclesiastical organisations.

5. The fundamental tasks of the Catholic organisations for accomplishing the mission of Christ: teach the Gospel and heal the sick. The needs of the single continents and the response of the national and continental Catholic organisations.

6. Principal challenges to the health care system of the single countries and of the continent as a whole.

7. The effort of the organisations to seek an answer to these challenges.

8. The prospects and essential objectives for the future.

9. The demands for an international organisation of Catholic Hospitals and Catholic health care institutions.

The speakers from the single continents will follow this outline as much as possible, basing their reports above all on the needs of their own countries and furnishing us with a more precise indication of their identity. This will demonstrate just how necessary it is to establish contact among the single countries so that the principal aims of the Catholic Hospitals and health care institutions will be coordinated in each continent.

WHAT IS A CATHOLIC HEALTH CARE INSTITUTION?

J. W. KWERI
Africa

Introduction

1. 1.1 The total area of Kenya is 569,249 km^2 and the population is estimated at 19 million people.

— The rate of natural increase of population is 3.9%.
— Crude birth rate 53.0/1,000.
— Crude death rate 14.0/1,000.
— Infant mortality rate 87.0/1,000.

The Kenya Catholic Secretariat is the executive arm of the Kenya Episcopal Conference. It carries out the day-to-day decisions of the Conference. The Kenya Catholic Secretariat has seven departments and is headed by a Secretary General. The Medical Department is one of the seven departments and is headed by a Medical Secretary. The Medical Department has a Medical Board which meets annually for major policy decisions and an Executive Committee which meets quarterly.

1.2 The Medical Department has under its umbrella 28 hospitals, 61 cottage hospitals and maternities, and 134 sub-health centres, dispensaries and mobile clinics. These health units are distributed all over the country and they account for over 25% of all the health services provided in Kenya. These Catholic health units provide about 5,380 inpatient beds and attends to about 5,000,000 outpatient cases annually.

1.3 Until about ten years ago, the main focus of our Catholic health services were curative with special stress on maternal and child health. Within the last ten years, our health units have greatly focussed on primary health care by establishing community based health care activities, expanded immunisations, nutrition, health education and natural family planning.

1.4.1 More than 50% of the total recurrent costs of our health institutions are met from fees charged to those availing themselves of the services rendered. We do receive about 15% of the recurrent costs from the government of Kenya in form of grants. It is our sincere hope that this grant will keep on rising.

1.4.2 There is a National Hospital Insurance Fund in the country. However, the contribution to this fund is only compulsory for those who are employed and earning more than K.Shs. 1,000/- (US $ 65) per month. Self-employed person can contribute to the fund if they so choose. Most of our hospitals are registered with the fund and contributors can claim from the fund through the hospitals. This money claimed by our hospitals from the National Hospital Insurance Fund accounts for another 20% of the running costs of our bedded medical units.

1.4.3 The remaining 15% of the recurrent costs of our hospitals are from the donated services provided by volunteer overseas staff—particularly from religious congregations and donations from Catholic health oriented organisations overseas.

The local Catholic church groups are increasingly making their contribution towards the cost of running curative approaches to health particularly through the community based health activities. In many of our capital projects, we do get substantial funds from various Catholic international organisations.

2. 2.1 The Church's concern for the sick is part of the Church's mission in the world, e.g. to manifest the love

and mercy of God. It is a continuation of the example given by Christ, who, when asked by John's disciples, described his mission as:

"The blind receive their sight and the lame walk, lepers are cleansed, the deaf hear, and the dead are raised up, and the poor have the good news preached to them".

This concern of the Church has gradually developed into the hospital today as we know it. A centre:

— where physical and spiritual needs are attended to,

— you are trained to give dedicated professional care,

— where the focus of attention should be on health and wholeness.

2.2 Yet they are centres of care which are becoming extremely difficult to maintain—both in staff and finances. In addition to their traditional mode of functioning, the Catholic Hospitals must also:

— adjust to a proper balancing between curative and preventive medicine, nutrition and hygiene promotion,

— take note of new orientations to broader based community health care,

— adjust to a new style of participative management.

Today's increasing emphasis on technology affects:

— the management and maintenance of these institutions,

— the overall picture of patient care and professional training.

2.3 A Catholic health institution must be seen in the context of the overall diocesan pastoral care. It is for this reason the planning of health services should be integrated in the planning of the other diocesan pastoral activities.

3. With the growing demands of advancement, and the considerable financial outlay required to ensure competent personnel, etc., the original ideal is in danger of being lost. We must face this challenge, to bring the Church's concern for the sick, to those in most need, the poor among whom

the hospital is situated. We must ask ourselves, what about the poor who do not come to hospitals—clinics? Why don't they come? How can we reach them?

The Catholic Hospitals and other health institutions in Kenya are called to:

— articulate and share with the staff, patients and local community the philosophy and goals which were implicit originally in their founding,

— enable team management, and staff participation in achieving these goals of the hospital,

— strive towards localisation of responsibilities in health care,

— encourage continuous updating of knowledge and skills among staff. This will assist in keeping alive the sense of dedication, and inspire the staff in their professional duties,

— ensure that social justice prevails in the administration, one evidence being just salaries and worker benefits.

4. There is no single solution to the problems of maintaining Catholic health services. There are several approaches that can be taken to economise, reduce costs, maximise resources. One approach is improved management-staff relationship, clear job descriptions, etc. Another approach is that of reducing medicine and hospitalisation costs by preventive health care. This is a long term strategy which makes sense, considering that 80-90% of our outpatients in Kenya clinics are treated for diseases that could have been prevented. It makes sense not only economically, but also humanly.

A Catholic Hospital exists for the good of the whole community, maintaining good health is just as vital as curing sickness.

The hospital as such exists to serve the community. Rooted in the community, it should be concerned with the general level of health of that community. The majority of Catholic health units in Kenya are already heavily com-

mitted to community health, maternal and child health, immunisation, promotion of good nutrition and hygiene, nutrition rehabilitation, demonstration gardens, etc. The style of community health care is that of service and teaching brought to the people by the professional health staff. It can, and does, have an impact on the health of the community.

5. What is the future of Catholic health institutions in Kenya? The effectiveness of community health care will be enhanced when the local people become active participators. In this sense, the health institutions must look beyond their "fences" to the people in their home situations. They must recognise the role of the Church health services in enabling the people to take increasing responsibility for their own health—helping them to appreciate their own store of knowledge and experience which in the past contributed to their health and survival. This is commonly referred to in Kenya as Community Based Health Care (CBHC). Community Based Health Care centres in the local community coming to an awareness of their health needs, becoming responsible for behavioural changes needed to effect improvement in their whole environment; in health, nutrition, sanitation, food production, etc. It implies that selected volunteers from the community itself accept a particular responsibility to become knowledgeable in health matters, and consistently promote good health in the local community.

6. The Catholic health facilities should continue to witness to the presence of Christ and his Church in many ways:

— by loving service, in professionally competent medical care,

— by training for professional and Christian service in the health field,

— by prevention of sickness,

— by promoting the good health and well-being of the whole community.

In other ways, also, the Catholic health facilities continue this witness:

— by testifying to the spiritual beliefs concerning life, the dignity of human person, suffering and death,

— by providing spiritual assistance to the sick, and

— by fidelity to Catholic and moral ethical principles, while ministering to the good of the whole person.

In looking to the goals of health and wholeness, there are other two significant measures that can—in the long run—reduce cost and achieve greater effectiveness:

— intensive attention to prevention of sickness,

— improved financial and administrative management of Catholic health facilities.

THE PARTICULAR NATURE OF THE CATHOLIC HOSPITAL IN LATIN AMERICA

NIVERSINDO ANTONIO CHERUBIN, M.I.
Latin America

For the purpose of this address we are counting as belonging to Latin America those countries on the American continent that were colonized by European nations of Latin stock. These countries number twenty, ten in South America, nine in Central America, and one in North America.

They cover the following geographical areas: in South America 17,320,000 square kilometres, in Central America 674,000 km^2, and in North America 1,958,000 km^2, totalling 19,952,000 km^2 for Latin America as a whole.

This area of the earth is inhabited by some 366,000,000 people, 255,000,000 in South America, 44,000,000 in Central America and 67,000,000 in North America. In the year 2000 the population of Latin America will have reached 550,000,000, one out of every eleven of the world population at that time.

The annual population growth rate in Latin America is very high—2.3% in South America, 2.7% in Central America, and 2.9% in North America. The annual average rate is 2.6%. But these averages conceal the existence of very sharp variations that are in inverse proportion to the social, cultural and economic development in individual countries.

All the countries of Latin America are graded as "Third World" countries, or developing countries, on the world scale.

Their racial composition is as follows: in South America, 42% of mixed blood, 32% whites, 18% Indians, 16% blacks and 2% of other races; in Central America, 43% of mixed blood, 23% whites, 16% blacks, 8% Indians and 10% of other races; in the country in North America, 50% of mixed blood, 27% whites, 11% blacks, 11% Indians and 1% of other races. On the average there are 45% of mixed blood, 27% whites, 10% blacks, 12% Indians and 6% of other races. Here again there are very pronounced differences; in some countries, in the southern part of the Isthmus, for example, the population is almost entirely white.

As for religion, a very high proportion of the peoples of Latin America are of the Catholic faith. The respective averages, for all countries, are 91.2% Catholics, 3.5% Protestants and 5.1% adherents of other religions. In three of the countries Catholicism is the state religion and in one country public manifestations of religion are banned.

As regards the economies of these countries, the World Bank classifies six of them as close to being developed countries, with per capita incomes in 1978 of from 1,410 to 2,910 dollars per annum, whilst 14 approached the level of underdeveloped countries, with annual per capita incomes varying between 480 and 1,290 dollars. If one looks at the course followed by annual personal incomes since 1960 down to the present day, it can be seen that the path on which Latin America is set has had the effect of enriching the richer members of the population 150 times faster than the poor have been rendered less impoverished. Two out of three Latin Americans had an annual income of less than 40 dollars.

The population of Latin America is predominantly young. In all the countries concerned, between 27% and 44% are under 15 years of age, whilst only between 2% and 10% are more than 65. The expectation of life, however, is very modest, varying between 51 and 72.

People's health in Latin America is very poor, and, according to UNICEF, over 50 per cent of deaths are

avoidable. The mortality rate is very high, although it has been falling substantially. In 1950 it amounted to 14.7 deaths per annum out of every 1,000 inhabitants, whereas in 1980 it had fallen to 7.7 deaths for every 1,000 inhabitants per annum.

Infant mortality varies from country to country, from 22 to 200 deaths in the first year of life for every 1,000 live births.

The diseases that are responsible for the vast majority of deaths are not new, but of a kind that have long been eliminated in developed countries: diphtheria, whooping cough, measles, poliomyelitis, typhoid fever, yellow fever, malaria, together with tuberculosis, the plague and leprosy.

Although their lands are among the most suitable there are for the production of foodstuffs, the countries of Latin America are already suffering from a chronic shortage of food. In 1970, 28 million children under five were undernourished, and malnutrition was the principal cause of death of those who died. Today, 52% of the population suffer from nutritional deficiences, and in particular from a lack of protein calories.

All the Latin American countries have some form of health service, but not all of them have a health programme that provides sufficiently integrated services, at present, for meeting the needs of the whole population. One of the measures adopted by these countries that provides a certain amount of security in the field of health was the institutionalisation of social insurance: although still inadequate, this provides an integrated system of assistance to workers in the towns and, generally speaking, partial assistance to its employees and country dwellers.

However, the amount of resources allocated for health is in inverse proportion to what is required. Only between 2% and 5% of the gross domestic product is allocated to the health sector, less than half of what is allocated in developed countries.

But the greatest problem of all for the health services and, consequently, for the populations of Latin America,

except in those countries that have adopted socialism, is the fact that therapeutic measures are given absolute predominance over preventive measures. Yet the respective costs are in the ratio of 8 to 1.

Hospitals are responsible for over eighty per cent of medical care in almost all the countries of Latin America, but they have forgotten that the predominance given to the use of therapeutic measures over preventive measures was already a blind alley as far back as 1910. Since then there is no one who is still in any doubt that preventive medicine is the main road to follow for finding a rapid, simple and economical solution to problems of health.

Hospital care in Latin America is provided by both public and private institutions. In all cases the latter are more in evidence and in some countries, but not in those with socialist regimes, amount to 90% of the total. It is private institutions, especially those of a philanthropic character, that provide health care in the small towns and rural areas.

There are also considerable differences in the grading of hospitals; some of them, especially in the large towns, are very equipped, but the great majority are badly equipped and unsatisfactorily dispersed, with inadequately trained staff and very poor administration.

Although it is a cause of great concern to both public and private institutions, it is believed to be an undoubted fact that nearly one third of the populations of these countries have only marginal access to hospital care. Another serious problem that rebounds against the services provided by the hospitals is that natural products, of which there is an abundance in all the countries concerned, are not utilised. Wide use is made of industrial pharmaceutical products, with some countries manufacturing over 20,000 different kinds, although the list distributed by the World Health Organisation recognises less than three hundred products.

Catholic Hospitals

Considering the status of the peoples of Latin America in regard to religion, it has to be said that, in practice, all the hospitals there should be looked upon as "Catholic", but not in a confessional sense. In fact this connotation, as applied to hospitals, implies that the patients or the hospital staff practice the Catholic religion. If, however, we take into account the legal status of the body responsible for hospitals, we find, ipso facto, that we are dealing with a category of private institutions, and these are always civil.

In Latin America it is the Church above all else that has always taken the lead in the building of hospitals, always being the first to arrive in places with no health service and setting up the first hospital unit, attached to the parish church. Though an institution of this kind is never known as a Catholic hospital but is rather called a "social institution", or community institution, and it will generally be maintained by the community itself.

So that we can look on all the hospitals in Latin America as being Catholic hospitals with the exception of those in countries with socialist governments, where the public practice of religion in hospitals is prohibited. Some hospitals, of course, are established and run by religious orders, dioceses, parishes, archconfraternities or lay institutions of the Catholic Church. In these, which make up 20% of all hospitals in the Latin American countries, the practice of what constitutes the essential nature of the Catholic Hospital should be more readily observable.

The basic guidelines to be followed by the Catholic Hospitals in Latin America, in reference to philosophy, theology and ethics, are those that have been approved for all Catholic Hospitals throughout the world, that is to say that earthly realities shall serve towards the true development of human values and, in regard to health, that there should be cohesion between health care activities and the faith that is professed, lest the institutions and individual activities concerned should possibly come to bear opposing witness.

These basic guidelines are founded on the following four points:

a) Christ is present in the sick.

The believer is called on to place himself at the service of the sick, and the greater the physical, social and psychological dependency of the person concerned the greater is the commitment that is expected of the believer. This approach is of heightened significance in Latin America, for here Christ's presence in the sick is far less manifest than in the developed countries.

b) Service to the sick is a living proof of the Church's mission in this world.

The Christian community is called on to translate into practice the wondrous heritage of faith and hope received from the Gospel. The Latin American scene shows particular activity in this field, since the numbers of the clergy, both secular and religious, are so limited that the Word of God needs to be spread between Christian and Christian.

c) Priority must be given in this service to those in the greatest need.

The lessons of Medellín and Puebla remind us that like Christ Himself, who felt especially deeply for the poor and abandoned, the Church is called on to make widespread and considerable compromises, since the problems that are generalised in them also affect the great majority of the population, and on a highly alarming scale.

d) The particular work undertaken in the hospitals provides the most propitious setting for the bringing of the Word.

The need for charity, bearing witness to the worth of the human person, and proclaiming the need for justice and equality among men are the salient points of the message to be preached, with the aim of transferring to the present day all those qualities to be seen in Christ as He went on His way healing, comforting, saving and giving guidance.

But apart from these fundamental precepts, which are valid for all Catholic Hospitals throughout the world, there are numerous others that are of particular relevance for hospitals in Latin America. For the sake of brevity we shall deal with three kinds only—those relating to health care and those of a spiritual and ethical nature.

Precepts Relating to Health Care

The modern concept of a hospital, whereby it is made into an instrument designed to keep people healthy as well as to cure them when sick, has so far been put into practice in only very few hospitals in Latin America, where the majority are concerned solely with the therapeutic aspect instead of acting as the guardians of the health of the community. Hospitals need to be open to and directed towards the community, and above all to perform services outside their own wall and to identify themselves completely with the way of life and aspirations and needs of the community.

All that the Catholic Hospital in Latin America needs to do in order to perform these functions is to implement, for a start, the measures that the World Health Organisation considers to constitute its reason for existence, namely:

a) *Prevention of illness.*

It should be the primary aim of every human being to preserve his or her physical and mental health and social well-being, since only then can the human personality be wholly fulfilled on this earth. The institution best suited to help people to achieve this is the hospital. To do so, it only requires to act as follows:

— to check regularly that pregnancies are normal and that delivery will be normal;

— to check regularly that children and young persons are growing and developing normally;

— to introduce immunisation programmes for the control of infectious and contagious diseases;

— to take remedial action against physical and ment disabilities;

— to educate the public by showing people how prepare their food, how to use water, how to dispose waste and how to avoid general and occupational disease

In order to put these precepts into practice, Cathol Hospitals will need to operate a general outpatient clin and to have a travelling team of health workers employe by the community to make regular visits to all the hous holds within their areas.

b) *Restoration of health.*

To restore the sick to health, Catholic Hospitals mu in the first place have a minimum of facilities for diagnosi with the necessary equipment, installations, medicamen and trained staff.

The struggle against disease must always be conducte at a sufficiently early stage. For this reason Catholic Hospita must identify themselves with the community so that the can find out in good time about any outbreak of disease If this is done, it should be possible for people to b restored to health without difficulty and quickly and a low cost.

The installations and equipment of a Catholic Hospita must be sufficient for it to be able to provide therapeuti treatment and perform operations for cases of commo disease or the usual kinds of accident. It must be in touc with other, better equipped institutions so that, where it i unable to deal with cases itself, the patients concerned ar never abandoned but can be sent to these other institutions

Catholic Hospitals must always be open institutions, no only in the sense that they take in anyone who seeks them out but also in the sense that they act quickly, at any hou of the day or night, to treat casualties or sick patient requiring immediate attention. To this end they mus have available the necessary installations, equipment an medicaments as soon as cases arrive, and also be able t arrange for the appropriate medical staff to arrive promptly

In Latin America, Catholic Hospitals should not be concerned with acquiring sophisticated equipment, and even less with having an elite class of patients. They should be content to provide, of course, basic care which, as is known, will suffice to serve the needs of more than 90% of the population, and at very low cost.

c) *Educational functions.*

Hospitals in Latin America find it difficult to acquire skilled staff in sufficient numbers. They tend to stay in the major centres, where it is easier for them to do well professionally and to earn more money. For this reason, the Catholic Hospital needs to be a veritable training hospital, and to train the majority of its medical team itself, with continual in-house training activities and the offer of opportunities to experienced medical staff from other institutions to practise their skills.

d) *Encouragement of research.*

Latin America is a rich breeding ground for numbers of diseases that do not exist in the developed countries. (Specific account should be taken of this, in terms of planning, materials and installations, when hospitals are built). There are very many natural products which, if properly prepared, can become extremely effective prophylactic and therapeutic agents. To encourage their use, Catholic Hospitals should back research, both in the area of medicine and of nutrition, on the use of materials, structural planning and administrative methods. This alone will favour the increased use of products, methods and models in keeping with the circumstances and characteristics of the Latin American peoples.

Religious Precepts

Although its peoples are predominantly religious, and Catholic, Latin America is a part of the world where there are fewer clergy than in most other parts. There has been an attitude, over the centuries, which has passively accepted

foreign missionaries, and no attention has been paid to t
fact that vocational work, if properly conducted, wou
easily and rapidly retrieve the situation.

It is therefore utopian to claim that Catholic Hospita
in Latin America can minister to religious requirements
the traditional way by having a chaplain who is availab
to patients, members of their families and staff for at lea
a number of hours every day. This only happens in lar
hospitals in the big towns.

In order to find a remedy for this situation, Catho
Hospitals in Latin America need to organise a system
pastoral work to be carried out by members of the loc
community in close collaboration with the local parish churc
The community served by a particular hospital can readi
provide a sufficient number of people representing t
community who can be given instruction in how to a
minister spiritual aid to the patients, so that they are ab
to pay daily visits, if necessary, to give comfort and teachi
and explanations, and to prepare patients in a suitab
manner for receiving the sacraments.

(It should be a simple matter to arrange for the pari
priest to contribute to this task, not only in connection wi
the patients, by administering the sacraments, but throug
regular meetings with the team of pastoral visitors to t
hospital in order to heighten their understanding of t
truths of our faith and to go through with them the metho
they employ in carrying out their work).

Catholic Hospitals need to pay particular attention
staff training. Besides giving training in medical and humar
care, they must never overlook the need to inculcate in t
staff how absolutely essential it is for them to look on the
services to the sick as a favour specially vouchsafed b
God; to make sure their patients look on them not only
skilled in their jobs but also as friendly and obliging peopl
who are anxious not only to see their patients recover the
physical health but also that they should recover or reta
their spiritual well-being. All the relations of the nursin
and medical staff must be based on and governed by th

Christian conception of Man. All hospital staff must be made aware of the pastoral aspect of their work. In this way the Church will be able to overcome the much discussed shortage of priests and members of religious orders and to keep the Christian faith vigorous and active.

The aim of pastoral work among the sick is to bring about the presence of God, to testify before all that God is love, that He is not the source of suffering or death, but that He came into this world that we might live, for which He Himself suffered and died.

Catholic Hospitals must involve the whole of the Christian community in this work, for all are responsible not only for their own well-being but for that of others as well.

One of the available means that can help to further this work in Catholic Hospitals is to apply to institutions which involve medical practitioners in pastoral activities.

Pastoral work among the sick includes a constant call for the humanising of the hospital. To humanise its organisation and activities in the service of the sick entails many different aspects, such as:

— the practice of social justice, which must always be placed in the forefront;

— regular instruction for staff to help them to keep up their feeling of vocation, which should in turn be their inspiration in the performance of their professional duties;

— never to forget the dignity of the sick person, and the need for the hospital to ensure that the staff, so far as is possible, are conscious of this when examining and treating patients, and aware that they may one day be patients themselves.

Ethical Precepts

One of the best means of imparting a distinctive identity to the Catholic Hospital in Latin America is to promulgate and apply a hospital code of ethics. Provided that this is

soundly based and correctly aimed it can become a rea source of protection for hospital, patients and staff.

For this to happen, the code of ethics applied by th hospital should contain the following principles, at least

— The human individual is the raison d'être of a human activity, and this applies in particular to healt care institutions.

— The dignity of the patient must always be empha sised, both as regards his willingness to undergo a particula treatment and as regards conditions in the hospital for th preservation or restoration of the patient's health.

— There must be a complete, fully integrated healt care system.

— The staff and specialist doctors must be sufficien in number and competent, and have a conscientious attitud towards any ethical considerations in regard to the arrange ments for patients.

— The hospital will on all occasions respect the per sonal and professional dignity of its staff and recognis their right to refuse to adopt methods or use equipmen and installations that might put at risk the safety an chances of recovery of patients.

— The patient is entitled to be told about his state o health and about the treatment he is being given.

— The patient has the right to be visited by the minis ters of religion of his choice.

— The hospital shall be sufficiently responsible in it attitude towards life and health so that the sick shall no be refused the treatment they need on grounds of failur to pay in advance.

Final conclusions

Health and health care are essential parts of life. The teach a respect for life that comes from God, the right t life and respect for the human being, created by God i His own image and in His likeness. The Catholic Hospita

especially in Latin America, is the most suitable institution for preserving health and healing the sick. So that it has both a crucial immediate function and the function of pointing the way: crucial, because it has to find ways and means of keeping alive millions of human beings who would otherwise have no protection against disease, and pointing the way because it is its task to present in itself an institutional model for allowing human beings to live to the full.

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ROLE OF CATHOLIC HOSPITALS IN ASIA

HERMOGENES B. PURUGGANAN, M.
A

I come to you this morning as a representative fro the Philippines upon the initiative of the Order of S Camillus which this year is celebrating their first deca of service to the sick in the Philippines; through a dedicate missionary Rev. Fr. Luigi Galvani, director of an unassumi primary health care unit called St. Camillus Pharmacy a Polyclinic based in Makati, Metro Manila.

I hope to participate in this Congress as the Philippi representative and as an Asian. I thank the Confoederat Internationalis Catholicorum Hospitalium for giving m this honor.

The topic of my presentation is:

1. Introduction

A) *The Major Characteristics of Asia*

1. The most populous of all the continents with th highest population growth rate in the world; hence a ve young population with 50-60% belonging to the pediatr age group.

2 The area is composed mostly of underdeveloped a developing countries with the exception of China, Japa Korea, Singapore, Hong Kong and Taiwan, which are no classified as new industrialised countries (NICS).

3. It is predominantly a non-Catholic and even non-Christian community. However, traditions and customs endow in them the valuable heritage where the spiritual is held in high esteem and where the religious sense is deep and innate.

4. Medically, it is claimed that health in this region "surprisingly has less to do with doctors, nurses, drugs or technology. Rather it is the environmental factors such as food, water, sanitation, housing, safe work conditions, maternal and child health and family planning". Dr. Halfdan Mahler, Director General of WHO has been quoted as saying that "tap water availability in this region is a better indicator of standard of health care than the number of hospital beds".

Health problems in Asia are predominantly the diseases of want—infection and malnutrition although the diseases of plenty such as heart disease, cerebro-vascular accidents and cancer are increasing.

The recognised health care solution is a political one through fundamental social, economic and cultural reforms.

B) *The Major Characteristics of the Philippines*

Population, 54 million.
Rapid growth rate, 2.2%.
65% rural.
55% children.
7,000 islands.
Agriculture/agriculture-based industries.
85% Catholic.
Health problem: infection and malnutrition.

Essentially the same conditions exist, with the exception perhaps of 2 factors—a population that is 85% Catholic and a territorial spread of 7,000 islands.

1. It has a present population of 54 million (from 19 million after World War II) with a steady population growth rate of 2.2% (from 3.5% a few years ago). 55%

of the population are children below 19 years and 65%
reside in rural settings.

2. It has a widely geographical dispersed populatio
with 7,000 islands. However, 90-95% of the total popu
lation reside in the 14 biggest islands.

3. A developing country presently in a precariou
economic state; it is heavily engaged in agriculture an
agriculture-based industries.

4. It is the only Catholic nation in the area where 85%
of the population is Catholic. Western culture has high
influenced its political, social and educational structure.

5. The core disease pattern consists of infectious disease
and malnutrition. Adequate solutions are compounded b
rapid population growth and poverty. It is reported th
as of mid 1984, 60% of families are below the poverty lin

C) *Philippine Health Service*

1. *Hospitals:* 1,946.
Bed capacity: 18,266.
Population/Bed: 3,000:1.

Notice the population/bed ratio of 3,000:1, a far c
from the 500:1 ratio considered as ideal among heal
planners of developed countries.

2. *Level*	*Private*	*Government*	*Total*
Primary	41%	9%	50%
Secondary	20%	15%	35%
Tertiary	9%	6%	15%
	70%	30%	100%

Indicates the role played by privately owned hospita
(70%) to the 30% government hospitals. However,
overall total beds the ratio is 55% private to 45% gover
ment.

3. (1983)

Catholic Hospitals and Clinics:	126	(6.5%)
Orphanages/Asylums	24	
Homes for aged	13	
	163	(8.3%)

There are listed in the Catholic Directory of the Philippines 126 (or 6.5%) Catholic hospitals and clinics out of the total number of Philippine hospitals (1,946). If one includes the other medical units of the church such as orphanages, asylums, homes for wayward mothers and the aged, the percentage will be 8.3%.

Unaccounted in this listing are the numerous consultation clinics for the poor manned by volunteer health workers upon the initiative of religious orders, mandated societies or the parish council.

4. *Hospitals named after:*

Jesus:	57	
Mary:	75	
Saints:	189	
Holy Family/Trinity:	74	
Other Christian:	35	
	369	(19%)

It is also interesting to note that in the registry of hospital names a total of 369 or 19% carry strong Christian appellations. Admittedly some of these are hospitals controlled and managed by Protestants.

In fact in the early part of Catholic involvement in health services, many of them were prodded to establish clinics to offset similar ventures by Protestant missionaries.

5. *Government Health Strategy*
Primary Health Units
42,000 barangays
1,991 rural health units

35 million rural population
33% unserved

The Ministry of Health has embraced the WHO Primary Health Care Programme as a strategy to achieve "Health for all by year 2000".

There is presently a mobilisation of approximately 42,000 barangays (small social and political units comprising families, totalling around 1,000 population led by a barangay captain and governed by a council. Usually in such a community a nurse, or midwife or a trained health worker who is a resident of that barangay is allowed to dispense first aid medications for common, uncomplicated ailments. There are also roughly 2,000 rural health units, each composed of a physician, a nurse and a laboratory or pharmacy technician. Around 35,000,000 (65%) of the 54,000,000 people reside in rural communities. Despite the Ministry of Health's dedicated and vigorous campaign to serve this rural population it is claimed by some quarters that as many as 11,000,000 (33%) remain unserved.

Faced with this predicament the Ministry of Health has moved toward private-government partnership through

— shared health planning;

— common use of available facilities and equipment with a system of remuneration;

— government subsidy for a number of beds in private hospitals for indigent patients over and above legal requirements for private hospitals to maintain a fixed percentage of bed for charity patients.

6. *Medical Schools*

University of Santo Tomas:	1871
University of the Philippines:	1906
3 others:	1960
29:	1985

The number of applications to the medical course has mushroomed through the years promoting the establishment of 24 medical schools within the past 10 years from a basic

core of 5 in 1960. This school year 1985, there are 27 medical schools admitting students. The total output of medical graduates as of March 1985 was 2,610 from 22 of these schools. The available internship positions are 3,027. Roughly the percentage of passing in the licensing board is 80%.

7. *Physicians* (40,000) 20,000
   (2,000 government service)
   Physician/Population 1:2700

8. *Nurses/Midwives* (146,000) 40,000
   (7,000 government service)

This shows the number of physicians and nurses/midwives licensed to practice their profession. The physician/population ratio indicated is the mean. Actually because of maldistribution, some urban communities like Metro Manila have ratios of 1:400 while in distant communities hardly accessible to transportation, the ratio exceeds 1:10,000.

Among nurses it is of interest to state that some 50,000 of them are in the United States or Canada with 20,000 concentrated in the State of New York. This is "brain drain" in the ultimate degree.

D) *Problems of Health Services*

1. Inadequate health budget;
2. Inadequate or maldistributed health structure manpower;
3. Exodus of manpower;
4. Population/Poverty;
5. Exorbitant costs.

Enumerated here is a summary of problems and conditions besetting the effective delivery of health care services despite adequate planning and health manpower training.

1. The problem of limited health budget where the amount appropriated for health is small compared to expen-

ditures for defense is shared by other countries like Burm Thailand, Indonesia, Malaysia and Singapore.

Solutions to those problems are difficult if not altogeth desperate. Who can we turn to but to government f correct policies to alleviate the situation?

2. The Catholic Church in Health Care Delivery

At this moment allow me to ask a few questions.

What is a Catholic Hospitial?

When is a hospital labelled a Catholic Hospital?

What distinguishes a Catholic Hospital from other

What is a Catholic Hospital?

1. Owned/Managed:	6.5-8.3%
2. Staffing:	(80-90%)
3. Policies	(50%)
4. Linkage with diocesan authority	

1. If it is ownership/control then the church involv ment is less than 10%.

2. The staff of most of these hospitals is clearly 8 90% by Catholics—from the doctors down to the low clerk or messenger. Direction and guidance of their expecte moral obligations as Catholics which should be exercise by the Catholic hierarchy is not clear and palpable.

3. If it is in the policies of the hospital where the is a conscious effort to abide by the moral norms promulgated by the Catholic Bishops Conference of th Philippines in December 8, 1973, then we can increas the number from 10% to a high 50%. Compliance to th norms of conduct as regards sterilization, contraceptio abortion and the recognition of life at the moment of co ception are, however, on a purely voluntary basis. Th ethics of many of such hospitals is often dictated by wh is in the operating room at the time, who is the Chief Surgery, who is the Chairman of the Board or the Directo

3. Principal Challenges

That the Catholic Church should continue to pursue its apostolate of caring for the sick, the handicapped and the helpless is not the question. It must. However, to do so more effectively, it will help to recognise the following:

A) *Internal*

1. Absence.
   Formal organisations.
   Referral system.
2. Apathy.
   Diocesan authority.
   Christian community.

1. There is no organisation of Catholic Hospitals in the Philippines although plans have been on the way for so many years. The recognised organisations of Catholic physicians and nurses have received lukewarm support in a country that is 85% Catholic. There are dedicated leaders but they do their work at great personal economic loss.

A system of referrals and the sharing of equipments, supplies and manpower is non-existent. I often have the feeling that the competitive rather than the cooperative spirit prevails among them.

2. The apathy of the Christian community may be the result of:

— lack of internalisation of their role in the healing ministry of the Church;

— lack of identification of the immediate community with the predominantly large Catholic medical centres catering to their needs;

— the inability of these medical centres to invite the community to a more active participation.

The degree of involvement of the Church in health care services has been dependent on initiatives of religious orders or congregations. Of the 34 religious orders for

men working in the Philippines, 5 are committed to a certain degree to organised health services. Of the approximately 65 religious orders for women, 11 are actively engaged in health work. On the whole, they operate as "missionaries" obligated not only to preach the Gospel but als to heal the sick, especially the poor.

3. The issues raised by Dr. Edmund Pellegrino in his article "Survival without Moral Compromise" is also felt in the Philippines.

"Survival without Moral Compromise" by Dr. Pellegrino:

— decline of vocations;

— commercialisation;

— moral pluralism.

— The decline in the vocations with consequent absence of the "religious" in the management of medical centre affairs.

— The commercialisation aspect where medical care is marketed as a commodity; where profit becomes the ultimate objective of the hospital industry.

— The "moral pluralism" pervading in contemporary society especially as it concerns community acceptance of abortion, sterilisation, euthanasia, newer reproductive techniques, the care given to the dying, the handicapped and the congenitally defective infants.

B) *External*

1. Philippines as "The only Catholic nation in the region".

2. Brain drain as positive apostolate of Church's healing ministry.

On the Philippines as the "the only Catholic nation in the region"—Pope Paul VI was quoted as saying: "At this moment one cannot think of the important calling of the peoples of the Philippines. This land has a special vocation to be the city set on the hill, the lamp standing on high giving shining witness amid the ancient and noble cultures of Asia. Both as individuals and as a nation you are to

show forth the light of Christ by the quality of your lives". We can then serve as an example for the rest of Asia in the healing ministry of the Church. The "brain drain" can be made a positive apostolate where Catholic doctors, nurses, midwives, technicians, pharmacists, medical administrators leaving for foreign lands may serve as apostles of the healing ministry.

4. Suggestions and Conclusions

Organise.
Examine objectives.
Maximize utilisations.
Facing problems.

In the light of what has been presented, may I make a few specific suggestions:

1. That the Church involvement in my country, and for that matter the whole of Asia, be geared primarily on the primary health care level. There is a lot of gospel truth in claiming that the health of the region is determined not so much by the number of hospital beds and hospital workers but rather the achievement of adequate supply of the basic needs of food, water, shelter and education.

The Church should continue setting up small health clinics especially in the unserved regions.

2. That the present commitment to Catholic controlled medical centres and hospitals be strengthened by being organised. That an organisation of Catholic Hospitals should exist. That the hand of diocesan authority as it emanates from the bishops should be felt.

3. That the Catholic Church as represented by the religious orders and lay leaders should show a deeper concern for the needs of the poor and to start dissociating from the image that they project—that of favoring the interests of the rich and the mighty.

I end this presentation with a reminder that the good Samaritan did not only stop to lend a healing hand to the half dead man. He left 2 silver pieces with the innkeeper with the promise to give more if it became necessary.

In the medical world, in the healing ministry, the lesson learned is love and charity.

WHAT IS A CATHOLIC HOSPITAL?

Dr. M. J. PAVONE
Oceania

1. Introduction

A Catholic Hospital is a special hospital. It is not just another hospital. As part of the continuation of Christ's Kingdom, all of its characteristics derive from the teachings of Christ and should be a living Christ in the particular community it serves. When aggregated with all other Catholic Hospitals in each nation the power for advancing His Kingdom is awesome. When one adds to each patient their families, when one considers the thousands of staff and their families, our health care system has immense power in doing good.

1.1 *Territory covered*

Australia is a large continent of approx. 7.7 million square kilometres with a relatively small population of 15 million people. The bulk of the nation's people are to be found on coastal areas and in two major cities, Sydney (3.5 million) and Melbourne (3.0 million). Health services are mainly concentrated in the cities. However, a costly network of hospitals and health services is needed to care for people in the country and in central Australia. Our Catholic health services are well represented in the six States and two Territories of the Federation.

1.2 *Number and type of institutions*

In the acute hospital area, Australia has 1,140 hospitals. Of the 59 Catholic, 22 are public hospitals, mainly govern-

ment funded and 37 are classified as private hospital
Among the extended care facilities for the aged, there a
130 Catholic nursing homes and hostels. There are al
non-institutional services, such as hospice care, and hor
or district nursing services.

1.3 *Main focus for care*

Whilst it is accepted that Catholic health care shou
focus on the poor or lower income sections of the co
munity, Australian Catholic facilities provide their servi
to all. Even the government funded Catholic Hospit
include fee paying patients who tend to be from the mid
or higher income members of the community.

1.4 *Means of support*

1.4.1 Role of governments

In Australia, governments, both federal and st
play significant roles in funding and controlling he
services. Our federal government has the main tax
powers and in addition to normal income taxes, the curr
health system receives additional resources by a special
levy on all taxable incomes. The federal government
substantially funds nursing home care in addition to
ments made by residents. As a result of these fun
arrangements, significant controls are made by governme
federal and state, relating to finance, management, sta
and roles.

1.4.2 Role of insurance plans

The main interests of insurance funds in this cou
are private patients in government or private hosp
They do not cover nursing homes, or the major pa
medical costs which are funded by the 1% levy on per
incomes. Other services covered by voluntary h
insurance are para-medical consultations, prosthesis, d
optical, etc. Controls exercised by insurance funds a
the amounts of reimbursement and on the number of
of acute care covered per patient per annum.

1.4.3 Role of Church groups

The vast majority of Catholic health services described above are owned and controlled by religious congregations. In the extended care services, recent developments have been provided mainly by lay groups such as St. Vincent de Paul Society or Knights of the Southern Cross. Australians have been generous supporters of the congregations both in kind and in service, e.g., by being on advisory boards or as consultants, financial and legal. Parish communities and their clergy have serviced their local facilities (Catholic or non-Catholic) as well as the main inner city Catholic institutions. In more recent times, in addition to the existing chaplaincy services, pastoral care services have been provided to non-Catholic facilities to cover their Catholic patients.

2. What then are the marks of catholicity which distinguish a facility as Catholic?

In summary I see these as:

1. Christian caring for poor and needy.
2. Organisation and management.
3. Pastoral caring.
4. Medico-moral principles.
5. Educational role.
6. Relationship with community.
7. Attitudes of personnel.
8. Leadership and forward planning.

2.1. *Christian caring for poor and needy*

The most important characteristic of a Catholic institution is excellence of its overall care to the poor and needy, manifest in the spirit of warmth and caring to be found immediately on contact. Whilst its physical signs are important, the over-riding critical factor must be the welcoming, sensitive, caring spirit that one really feels on entry and throughout the facility. Thus, those in need will have

no hesitation in seeking assistance; those who refer patient to a Catholic Hospital will do so with confidence and surety

Catholic Hospitals respect all involved, meeting patients and their families' needs for consolation, for advice, an for pastoral assistance.

A Catholic Hospital should include in a prominent an accessible position a special place for prayer and ministry The range of sacramental and spiritual assistance availabl must be comprehensive so that the most important healin of all between man and God can be facilitated. In ou facilities, suffering and dying are not meaningless—w endeavour to assist all patients to see the divine plan fo salvation at such times.

2.2 *Organisation and management*

The direction of a Catholic facility is set by its leader the managers. Delegation of vocational tasks means th the Board of Management, Sister Administrator and Chi Executive Officer should adopt the highest objectives ar standards for the activities undertaken therein.

2.3 *Pastoral caring*

Every encouragement should be given for all staff, f voluntary helpers and for visiting persons, to be pastoral oriented.

In addition to helping the patients and their relative pastoral care is necessary for the carers, such as docto and nurses.

In our hospitals at any one time, there are patients many faiths, and it is charitable and Christ-like to obta appropriate ministry for these persons.

2.4 *Medico-moral principles*

A Catholic Hospital must give clear and explicit witne to the spiritual aspects of health care in accordance wi Catholic principles. Utilitarian objectives have been urg upon the community stressing the limitation on resourc

which can be directed to health care. A Catholic Hospital is one which continues to give first place to God's values and love.

2.5 *Educational role*

There are a great many education needs which a Catholic facility can fulfil. Special skills are required by our leaders, managers, our pastoral care group and all staff. In Australia, our hospitals have given significant service in the education of doctors, nurses and others.

2.6 *Relationship with community*

Community relationships include those with the immediate local or parish level or in the wider context with various authorities, Church and governments and other agencies, non-Catholic, non-health oriented groups.

2.7 *Attitudes of personnel*

The morale throughout a Catholic hospital needs to be high. There are established principles for good structure and management of ordinary health facilities. Staff must be sensitive to the needs of others, to the needs of patients, excellence in care, including spiritual aspects, privacy, respecting human dignity, and respecting confidences.

It is in these ways that a readily perceptible spirit of caring is seen in Catholic facilities.

2.8 *Leadership and forward planning*

Our Catholic health services need to be seen as efficient, sensitive and covering the needs of the community they serve.

In Australia we have today a very significant health caring resource, and a most visible organisation fulfilling Christ's mission to heal and comfort. There is a continuing need for able leadership from bishops, major superiors of religious congregations and lay leaders in the Catholic health care field.

3. Principal challenges and responses

The prime challenge is to maintain and develop ou Catholic health services. The ways to overcome the challenge can be discerned if we clearly identify our problems. Th perceived difficulties for our facilities centre on maintainin the Catholic philosophies and basics scheduled above.

3.1 *Christian caring for poor and needy*

How is this environment created? The simple answer for all involved to be Christlike. The reality, however, that achieving such a range of qualities is a challenge an a struggle. There is a need to state clearly our Christi philosophy. This needs to be written in words, as in t Statement of Philosophy, now commonly found in mo Catholic hospital literature on the first page. Words a hardly enough and they require substantial complian

3.2 *Organisation and management*

A major responsibility of the governing body is t selection and nurturing of its own constituent membe Board members need to have varied skills but of ma importance is their acceptance and commitment to Christian mission of health care. Such attitude in leaders is a prime pre-condition for a flow of the sa spirit to the Chief Executive, to all the staff throughout facility. The effectiveness of management needs to enco pass primarily the true reasons for the hospital's existen the special marks of a Catholic Hospital. The use of ev uation criteria, such as those already available, should a principal part of a board meeting. It should be m important to review our monthly achievement as a part Christ's ministry than it is to look at financial data medical statistics.

In Australia in recent times we have been giving car attention to ensuring that Catholic Hospitals have appropr formal legal status, either separately or as part of its

gregation's structure. Such a provision is essential in the Western world where legal challenges may be made upon the facility from varied sources.

3.3 *Pastoral caring*

A pastoral care group is essential and needs to be supported appropriately, given our acceptance of the importance of spiritual healing. It should be emphasised. however, that the existence of a Pastoral Care Department can lead to others avoiding opportunities for involvement. The Department itself has a vital responsibility to share the caring spirit amongst the staff.

Sufficient training must be undertaken to provide skilled pastoral care.

3.4 *Medico-moral principles*

Catholic Hospitals need ethics committees and protocols for determining more complex matters which arise in the medico-moral area.

Sufficient study time should be available in educational programmes for doctors and scientists to review whether current developments made are or are not in conflict with Catholic moral principles.

Beneficially, Catholic bio-ethics centres have been established to study difficult problems.

The need for Catholic Hospitals to use ethical guidelines approved by the local bishop has been recognised.

3.5 *Educational role*

There is a clear priority for our hospitals to provide a balanced education to health careers, in particular doctors and nurses who have the closest and most vital contact with patients and relatives. Their educational programmes need to concern all aspects of the human person, intellectual, physical, spiritual and emotional.

In Australia recently, nursing education has moved into tertiary colleges away from the hospitals which were educat-

ing and providing clinical experience on site. An endeavo
is being made to have a Catholic nursing college in as ma
States as possible.

3.6 *Relationship with community*

In its dealings with government, a Catholic Hospi
should maintain a responsible attitude to carry out the gene
roles expected of it without compromising any of its pr
ciples. Reference to Church authorities, use of eth
committees and advice from the local Bishop are all requi
on any controversial requirements sought to be made
governments. With the support of our bishops, ma
religious superiors and facilities, state and national hea
care associations have been formed to provide links w
governments and others.

Another important relationship is that between the l
parish and the Catholic Hospital. Our hospitals sho
provide more services out in the community, various supp
services, home nursing, hospice care for those who w
to die at home, through the use of their substantial resour

3.7 *Attitudes of personnel*

The challenge is to select health care personnel carefu
They need ongoing education in the objectives of a Cath
health facility.

3.8 *Leadership and forward planning*

As vocations to the religious are declining, a ca
programme for involvement of the laity is essential. T
needs to be special educational programmes to assist
health administrators.

The pastoral needs are such that our prayers and ene
must be directed to have sufficient ministers to serve
people of God. During hospitalisation, patients are at t
of greatest stress and greatest turmoil and the sacram
of Reconciliation, of the Eucharist and of the Sick
to be administered. Pastoral care to the healthy pe
is important; to the sick it is vital.

An excellent Catholic facility engages in forward planning, ensuring its objectives can be met. Encouragement of younger people to take the places of dedicated older staff is important so that a vacuum does not occur as staff resign or retire.

Over the past decade our national association has been developed to assist Catholic health care institutions. In this last three years a full time staff has been engaged to provide consultancy and other services to assist Catholic health services to be vital and effective.

4. Prognosis for the future and conclusion

Finally, the staff in a Catholic Hospital must recognise the promise of struggle and sacrifice inherent in any activity centred on carrying out Christ's mission as perfectly as possible. We can succeed because the Spirit supports good works and His workers.

Under His inspiration, our future rests on co-operation between all participants at local, diocesan, state and international level.

WHAT IS A CATHOLIC HOSPITAL?

Dr. CHRISTIAN KUHN
Europe

1. Introduction

1.1 *The part played by the Catholic Hospital in patient care, the number and types of institutions*

As an example of the situation in the region I have been asked to talk about, the European countries, I propose to take the situation in Austria, my country of birth, where, as a lawyer, I act as adviser to hospitals run by the religious orders, and also say a little about West Germany. In both countries the proportion of health care institutions, where the legal entities concerned are Catholic institutions, is just below 20% of the total health care facilities in terms of the share in the number of beds. This means statistically in the case of Austria that out of a total of 56,188 beds in health care institutions 10,648 are administered by Catholic institutions (1984 figures).

In the Federal Republic of Germany, Catholic institutions are responsible for 143,612 beds out of a total of 722,953 (1983 figures).

In the German Democratic Republic, a country that is under a Communist government, according to a report by the DDR news agency there are 82 hospitals with around 12,000 beds that are run by the churches and religious groups.

It is no exaggeration to say that in the case of both Austria and West Germany it is inconceivable that the

present system of health care could operate without the Catholic institutions.

I have decided to discuss Austria and Germany, among other reasons, because each country presents a different picture in regard to the entities concerned with the management of Catholic health care institutions. In Austria it is for the most part the religious orders which are the entities concerned, whereas in Germany the position is different: of the total of 629 Catholic health care institutions, only about a quarter are in the hands of the religious orders, the remainder being run by church parishes, foundations, institutes and associations.

In both Austria and Germany the health care institutions run by institutions of the Church are of many different kinds: there are general public hospitals, general private charitable institutions, special homes, nursing institutions for the chronically ill, and sanatoriums. All forms of health care institutions, including sanatoriums, I believe to be a special Christian charge, and that their existence is therefore justified. In contrast with the position in North America, at the Cardinal Ritter Institute in St. Louis, for example, follow-up care for discharged patients is still not a prominent feature. I feel there is still a great deal in future to be done by Catholic institutions in this field, especially as it is one in which the need for funds is less in the forefront.

1.2 *Problems of finance*

Every hospital, including of course every Catholic Hospital, needs a vast amount of funds if first-class medical care for the patient is to be ensured. The financing of health care institutions is undergoing just as much radical change in Austria as is the case in other European countries and in America. The reason for the new direction taken in the system of finance is the explosion that has occurred in health care costs, something which threatens the very existence of Catholic Hospitals. Under the system of financing practised hitherto in Austria, a hospital receives a per diem contribution towards the cost of patient care from the

national health insurance authorities, but this is far from being enough to cover expenditure. The resulting deficit, in the case of some Catholic Hospitals, is partly made up by the State. The body corporate of the hospital has to fund the remainder.

Since it is impossible for a public general hospital to be managed at a profit, running a hospital entails a drain on the corporate capital: and for the bodies in charge of Catholic institutions, which are engaged in no other forms of operation that could bring them in proceeds, this is a threat to their existence.

In Austria a fund was set up as a means of providing finance to which the federal government, the separate state governments and the health insurance authorities all contribute, out of which contributions are paid out to the health care institutions, on the basis of a complicated quota system, towards operating losses and capital spending. The religious orders' hospitals also have a say in the administration of the fund. However, the creation of this fund failed to lead to any appreciable savings, so that in Austria new financing methods are being tried. New financing systems are due to be introduced in 15 hospitals with effect from the beginning of January 1986, including, among others, the American DRG system and the Dutch budgeting system. The system which proves to be the best as a result of this trial phase will be the one to be applied in future in reference to the financing of health care institutions.

I must not fail to mention that private sickness insurance schemes have taken on, in Austria as in America, an important role as regards the provision of finance. In America the term used in this connection is "cost shifting". But these days the private sickness insurance institutions, which as a result of the ever-increasing rates of contribution that they charge have been getting fewer and fewer contributors are no longer in a position to take on this financing role.

In the long run the problem of finance will only be solved if the rates of sickness insurance contributions to be paid by contributors are increased, particularly in Austria

and Germany, where—as opposed to the position in the USA—almost every national is a contributor to the national health insurance fund. But then, as regards the burden on the individual, we shall be coming up against the limits of what burdens can be imposed.

But the material deficit experienced by the Catholic Hospitals in only one side of the coin; any shortfall in ideals could be equally threatening.

2. The fundamental constitution underlying the Catholic Hospital

When, two years ago, I had the opportunity on the occasion of a trip through North America to visit a number of health care institutions run by the Church, I was struck by the fact that most of them had a notice-board near the reception desk which told one which authority was running the institution and the nature of its aims in the way it exercised its management.

What are the essentials, then, that distinguish a Catholic Hospital from any other hospital?

The difference lies in the nature of the justification for and in the mission attached to the work done by the Catholic Hospitals. Health care institutions administered by the state authorities derive their justification for existence from the duty of the State or its institutions to ensure that its nationals will be provided for if they fall ill. The institutions belonging to the Church can claim that they have another underlying task, to fulfil Christ's commandment as handed down to us by St. Luke (10.9): "Heal the sick and preach the Gospel".

Health care institutions belonging to the Church, in addition to the humanitarian motives shared by all such institutions, have a Christian motivation and the duty of fulfilling Christ's commandment according to the principles of Christian ethics and Catholic morality. This in my view is the only real point of difference between them and other health care institutions. The Catholic Hospital, apart from

dispensing medical and psychic care, is required to provide care in matters of religion. To people who are sick the question of what life means is posed in a particularly insistent form. Dispensing the comforts of religion is primarily a task to be covered by pastoral work at the hospital. "I was sick, and you visited me". And the body of the Church has given us a clear sign in setting up the Pontifical Commission on apostolic work among the sick through the motu proprio *Dolentium Hominum*.

This, it seems to me, is one of the main tasks for the future: the authorities responsible for health care institutions belonging to the Church must show the nature of their Christian motivation, and distinguish it from humanitarian considerations. This means more than merely preventing health care and welfare institutions from being placed under state ownership. It means, among other things, helping the sick to see some meaning in suffering.

But Christian motivation is not to be expressed in the kind of "pathological infatuation with suffering" as manifested in this kind of phrase: "O God, the more suffering you send upon me, the more You love me".

How can this be achieved, or how are the health care institutions in Europe, particularly in Austria and Germany, trying to achieve it? It has been realised for some years that individual institutions do not have sufficient resources to give articulate expression to their interests on their own, whether in reference to hospital finance or to finding solutions for the new problems that are always emerging (such as, for example, prenatal diagnostics, sterilisation, the right to die with dignity). This is the reason for the creation of umbrella associations such as the German Catholic Hospitals' Association Incorporated, or the Austrian Religious Orders' Hospital Study Group. Both these institutions endeavour, by means of regular activities and appearances in public, to give to Catholic institutions concerned with health care the weight and say which, in view of their contribution to health care as a whole, is only their due.

Of the many concrete example of initiatives with a view to bringing out the Christian motivation underlying our activities, I should just like to mention the basic constitution for Catholic hospital authorities formulated by the executive committee of the German Catholic Hospitals' Association and the stipulations proposed for adoption in service contracts with doctors that have been formulated by the Austrian Religious Orders' Hospital Study Group, with a view to having hospital staff bound by the same Christian motivation as that with which the authority in charge of the institution is itself imbued.

3. Requirement for the future

Besides finding an answer to the problems in connection with safeguarding the provision of funds, which has been explained already, the main task, it seems to me, facing the Catholic health care institutions is this: despite the decreasing numbers of staff belonging to religious orders or to the Church who are working in Catholic Hospitals, to give expression to Christian motivation and to ensure that Catholic principles are safeguarded. That this can be done has been shown by the Brothers Hospitallers in Austria, who have succeeded in preserving the character of a Christian hospital in their hospitals, although at present there are now only 2 or 3 still working in them.

But it can only happen if the body corporate responsible for a hospital is in fact and in law in a position to determine what is done in its own hospital, and to see that its staff are held responsible. For legal reasons and also for tax purposes we are looking for new forms of body corporate to manage our health care institutions. We have formed institutes, associations or other artificial persons so that the religious community as such, for fear of problems arising in relation to civil liability or the risk of non-financeability, can remain in the background. But in our search for new forms of legal entity there is one thing we must never overlook, something we should be positively adjured not

to do: it must be made certain that the religious institution which is in fact the body responsible for the hospital can always exercise its influence directly and immediately, and that the hospital is not independently managed. If this should happen, then the difference from any other kind of hospital that has been referred to, through the existence of Christian motivation and management based on the principles of Christian ethics and Catholic morality, could well disappear and no longer be given expression. Our hospitals will then have lost the spiritual reason for their existence, since medical care alone can be provided just as well by any other kind of health care institution.

4. Conclusion

I should like to close with the words of the Austrian Father Anton Gots, of the order of the Ministers of the Sick, who tells us, with Luke:

"A Christian hospital is a hospice where God in Christ Himself delivers the sick and leaves the means and the command for them to be tended to in His name. A modern Christian hospital fulfils this command by means of the resources of present-day science, technology, economic management, leadership and pastoral care".

WHAT IS A CATHOLIC HOSPITAL?

Dr. JOHN E. CURLEY Jr.
North America

Good afternoon,

I have been asked to speak about the Catholic health care ministry of the continent of North America. Consequently, I am privileged to offer observations drawn from the experiences of the Catholic health care ministries in the United States and in Canada.

In the United States, the ministry embraces nearly 650 acute care institutions and more than 500 long term care facilities and services. Together, they care for more than 46 million persons annually, employ more than one-half million employees, and generate, in the aggregate, total expenses in excess of $20 billion annually. Although primarily and necessarily institutional-based, recent years have seen a marked emergence of non-medical, community-based models of care.

It is the tradition in the United States to offer health care services through private initiative. For example, of the nearly 7,000 hospitals in the United States, fewer than 2,000 are operated by government jurisdictions, and a majority of long term care services are privately funded. Similarly, until the last 20 years, most health care was financed through private means, including indemnity insurance, prepayment coverage, philanthropy, and so on. During the last 20 years, with the advent of federal and state programs to assist in the financing of health care for the elderly and the poor, all forms of public financing of health care have risen to above 50% of the total.

In Canada the 175 Catholic health care facilities offer the full spectum of holistic care in acute, chronic, or nursing home contexts including some large teaching hospitals. Most of these facilities are run by 28 different religious congregations; a few are owned by Catholic foundations or councils and are managed as Catholic health care institutions. All are committed to serving the needs of their people in a variety of ways and are increasingly involved—within their respective communities—in outreach programs that have wellness promotion and illness prevention characteristics.

Without exception, all health care facilities in Canada participate in financial support furnished by a government sponsored, hospital/medical insurance program. Accordingly, all Canadians have the majority of their acute and chronic care needs covered by this plan. For health care facilities, Catholic institutions included, this means that approved operational expenses are reimbursed through this insurance program. Capital expenses in most provinces, and the great proportion of such expenses in the other provinces, are also covered. In this context, therefore, the Church's presence through its institutionalized approach to the healing ministry is somewhat different from that in many other countries. Catholic health care facilities in Canada are challenged to give leadership both in identifying the needs to be addressed and in the style of presence and management of their institutions. As owners, religious congregations, and others as managers of Catholic health care facilities, are called in a special way to be a leaven in the whole Canadian system. They respond to this call by promoting the culture of each facility, especially by attempting to have all those associated with it—staff, physicians, managers, board members—internalize the mission statement, that is, come to understand and implement what the institution says is its *raison d'être.*

In short, this data reflects Catholic health care ministries in the United States and in Canada which are vital and

vibrant, and which are enormously important both within the Church and within our pluralistic societies.

The Catholic health care traditions of both countries date back to before their founding as nations. From that time to this, principally through the dedication and sacrifice of religious congregations of women and men, our ministries have followed emigrant populations into every corner of our respective countries. Today, the presence of Catholic health care enables the Church to meet its ministry obligations and to seize its witness opportunities in every state and province, in major metropolitan areas, in small towns, in rural settings, on the campuses of major academic centers, in remote outposts, and in inner-city neighborhoods. In short, our Catholic health care ministries are completely woven into the fabric of our two nations and their diverse peoples and cultures.

Similarly, we are fully a part of the Roman Catholic Church in our respective countries. Although generally owned and operated separately from the dioceses, it is common for individual institutions and services to work closely with the other Church agencies within their respective local Church settings. At a more national level, our ministries have organized for collective effectiveness. Through the Catholic health associations of Canada and the United States, our ministries enjoy collaborative relationships with a variety of national Church organizations, including those of the bishops, of Catholic charities, and others. We cooperate on numerous public policy, advocacy and legal issues spanning a range of interests from care of the poor to treatment of handicapped newborns to tax-law questions to medical experimentation, including genetic engineering. In every instance, because of our presence and our expertise, the Church has a practical platform from which it can speak authoritatively to the compelling health-related moral issues of our time.

Our presence is not without its difficulties and challenges. We live in a time of extraordinary change. In the interest

of time, I'll cite only a few of the major issues affecting our ministries.

Always perceived as "rich" nations, Canada and the United States are today attempting to resolve public policy dilemmas regarding the allocation of increasingly scarce or limited resources. Relative to health care, this fact, coupled with the secular nature of our respective societies, suggests that the Catholic health care ministry will have increasingly important opportunities to bring the Church's value tradition to determinations of *who* receives *what* care and under *what* circumstances. Included among our primary concerns are those life-value issues flowing from health care which attack our understanding of the sacredness of life and the dignity of the human being. Further, we are working very hard to assure that people with special needs, particularly our nations' poor and infirm elderly, are not relegated to a "second class" health care status.

New frontiers in science and exploding technologies are conspiring with the complexities of "big" business to obscure society's responsibility to people in need. Always in the forefront of professional and technical excellence, our ministries today are taking the extra steps to assure that the personhood of patients is not lost in an impersonal medical and management maze. Science and business are both necessary and important, but the best interests of the whole patient are most important. That's why a value tradition that incorporates pastoral care, social services, chaplaincy, ethics committees, and corporate interest in theology and medical-moral issues is so central to the mission of which we are stewards.

Like the public policy arena and health care generally, our Church ministries are also changing. The decline in the number of consecrated religious and the emergence of the laity promise changes in more traditional forms of sponsorship. Similarly, as our ministries seek new governance and operational forms, compelling questions regarding Church-relatedness and Catholic identity will necessarily be addressed.

These and numerous other issues are all expressive of the vitality of the Catholic health care ministries in Canada and the United States. They are the signs of Church ministries actively engaged in the task of bringing Christ to a wounded world. More importantly, they are the ways by which Christ, through us, is called to be present.

In His Gospel, St. John recalls for us the priestly prayer of Christ at the last supper. In part, Christ said:

> "I am not in the world any longer, but they are in the world, and I am coming to you. Holy Father, keep those you have given me true to your name so that they may be one like us".

You and I are in the world. In what ways are we being called to express our "consecration in the truth", to evidence our fidelity to His word? Perhaps one indicator will be the manner by which we, as ministers, address the questions which are shaping the future.

Relative to our world

Do we fully appreciate our opportunities and obligations to make Christ more fully present within society, to be creative and Christian agents of change?

Do we make full use of all of the vocational, professional, political, economic and legal tools which may be available to us?

Are we prepared, by our commitment and competency, to engage the central moral and ethical dilemmas of our age?

In short, do we recognize our stewardship obligation to help our world achieve even more for all of His people?

Relative to our Church

Do we fully appreciate our opportunities and obligations to make our Church more fully and really present within our respective ministries?

Do we recognize our responsibility to bring our medical and health care knowledge and experience to the Church's Magisterium as it strives to preserve doctrinal authenticity

amidst the tension which so often characterizes the relationship between teaching principle and pastoral application, between tenet and practice?

Do we seize our unique opportunities to assist our Church to understand and shape the use of our discovery of new knowledge, new science and new technology?

In short, do we recognize our stewardship obligation to help our Church achieve even more for all of His people?

Relative to our ministry

Do we fully understand our opportunities and obligations to evangelize by example, to be the leaven in a society which too often either refuses to acknowledge the needs of people or reduces problem solving to quick-fix solutions?

Do we always seek to internalize the teaching values of Christ and his Church, not only in terms of the care we provide but, more fully, in terms of our responsibilities as Church members, as community citizens, and as employers of people?

Are we open to the changes which are shaping our own health care environment—the risk of new knowledge—the shift from acute to chronic care—the many fundamental and profound changes which are occurring within the practice of medicine itself?

In short, do we recognize our stewardship obligations to help our ministry achieve even more for all of His people?

In that sense, all of us in Canada and in the United States are like all of you throughout the rest of the world, whether clergy, religious or lay, whether Catholic or not, all of us joined within the universal Catholic health care ministry share a common bond—we have heard Christ's call. And, by our presence, we are calling others to turn to our communities of healing—some to heal, some to be healed—all to be enriched by the value tradition we represent.

We, your brothers and sisters in Canada and the United States, are proud to be joined with you in bringing Christ to all the people we care for.

THE MISSION OF THE CHURCH IN THE WORLD OF HEALTH
(PASTORAL, ETHICAL AND POLITICAL ASPECTS)

Father CALISTO VENDRAME
Superior General Servants of the Sick (Camillians)

Introduction

As you see from the title, my presentation goes beyond stating the position of the Catholic Hospital. It seeks to be an invitation to reflect on the broader horizon of the Church's mission in which it is situated and should be understood.

Having to keep in mind the international situation, and having only fifteen minutes at my disposal, with the sole purpose of starting a dialogue, I will restrict myself perforce to the general, trying not to be generic. I will try to call attention to several points which I hold essential for this morning's dialogue.

Mission of the Church

In the first place it must be clear that it is the right and the duty of the Church to be present in the world of health, if it is to be faithful to the mission received from Christ: "Preach the Gospel, cure the sick".

Christ came so that man would have life and could live in fullness (cf. *Jn* 10, 10). That His mission should not be limited to the spiritual sphere is evident in the pages of the Gospel, where He always appears surrounded by a crowd of sick people of all kinds. "Jesus continued His tour of all the towns and villages ... He proclaimed the good

news of God's reign, and he cured every sickness and disease" (*Mt* 9, 35). In fact, curing the sick was a sign of His Messianic mission (cf. *Mt* 11, 3-5).

For that reason, even if it has not always been known to use to the full the force of salvation contained in its mission, the Church has always claimed service to the sick as its precise duty and inalienable right (*AA* 8c).

New challenges

In the world of suffering the Church has always sought to be the light of Christ that lights and the expression of the love of God that opens hearts to hope.

Today the Church finds itself facing a profoundly changed reality that has become large and complex, that well deserves the name of world. If the world of health has always been the mirror of society, today it is so more than ever, and continues to present the Church with new challenges that it absolutely cannot confront with antiquated methods.

With scientific and technological progress man has become more aware of his power even over life and death. That which was once left to providence, to destiny and to religion, today is assumed by society as its primary task. To live and take advantage of all the opportunity that a healthy life can offer seems to be the supreme aspiration of the man of today. Everything is aimed at caring for his health and keeping himself fit, to be active and to enjoy his well-being. The discoveries in various fields of knowledge, and huge economic resources are put to the service of health. Places of care have become advanced posts of science and technology. Almost everywhere the State is assuming, as its right and duty, the health care of its citizens, with the limitations that we all know.

Thus the Church has lost its role of protagonist of health, and risks losing also its evangelical mission if it does not adopt new forms of presence in this broad sector of society, forms more in harmony with the new reality.

To be present

In its specific role of announcing the word of God and bringing the salvation of Christ to all of society, the Church must extend its presence beyond the traditional one of its own charities, and proclaim, and possibly build, the Kingdom of God inside and from inside the entire large and complex world of health.

To reach the conscience of the people who carry on their own activity there, sporadic intervention, as of an "outsider", is not sufficient. In this world in which methods proved by experience are used, guidance that comes from the outside, dictated by philosophical and religious principles, will hardly be accepted. It is only from the reality in which they live, from knowledge of the socio-cultural context and from the orientations that direct progress and influence the *ethos* in the world of health, that one can insert the Gospel message that illuminates and transforms, that enlightens consciences, that questions and converts.

Only thus can the Church, in her evangelising mission, be the critical conscience of the health community, only thus can she make herself protector of man and promoter of human values and of the quality of life.

Social commitment of the laity

All this is not possible without a social and political commitment of lay Catholics. A great evil denounced by Vatican is the divorce between religious practice and life, or rather, the making Christianity something "private", that in certain countries ends in permitting dictators to eliminate the innocent, and at the same time devoutly recite the rosary, believing even that they are rendering service to God.

Hence the urgency of an evangelisation of true Christianity, that goes to the bottom of man's heart, that opens it not only to God but also to one's neighbor, that never detaches religion from life, from human values, from

solidarity with the people, that leads to understaking all the social and political implications of faith.

A Church that would alienate itself from the problems of society would lose its role of guidance. Its battles for life would be lost at the start, opposed by Catholics themselves.

Only the presence of clear and consistent Christians can prevent the world from becoming a "social laboratory" where narcissism, the search for prestige and pleasure, dominates, and where the person who does not produce and does not consume is marginalised.

Ethical dimension

The field of health is the place where decisive facts for man's life happen, where one is born and one dies, where experiences are lived that strongly affect the body and the spirit, and determine profound changes in the type of life in society, and frequently in the psychic and spiritual attitudes of persons. It is also the place where ethical and moral problems are posed most acutely, urgent and always new, from the moment that the progress of science and technology puts at man's disposal new possibilities, be it for living or for dying, be it for prolonging a life with therapeutic tenacity, or for interrupting it at its inception, be it for preventing conception or for obtaining it at all costs.

A temptation difficult to overcome is that of dictating norms deriving from principles which are apparent only to one who has a vision of faith. You do not construct a building, beginning at the third floor. There is a real work of excavation to reach to the bottom of the heart, to the solid rock of the deep "I", where man finds himself alone with his Creator and where he must decide his destiny.

Only when a man has a true vision and a free, responsible attitude in his rapport with God and with others, is a discourse on particular points of professional ethics possible.

On the other hand, one cannot do without the contribution of the human sciences, of typical culture and above

all of the *ethos* of the world of health, of the truth of man (not only of the truth about man).

In a pluralistic society that one keeps in mind and faces at the crossroad of health, interdisciplinary dialogue that is aware of the diverse concepts of man and of his destiny, is the best way of casting the light of Christ on all human problems that explode around life and health.

But it is the entire vision and attitude of society in its daily life that prepares man to confront problems that are posed in dramatic form when life is in danger. Hence the need of evangelisation not limited to hospital walls. Man must learn to live and to die in a human, Christian way before crossing the threshold of the hospital.

Political implications

As a consequence of the development of medicine and of the consciousness of the right of the citizen to health care, the world of health has become an essential part of the politics of a nation, with all the advantages and all the disadvantages that this can mean.

If the civility of politeness of a people is measured by its attitude towards the weakest, we can say that the politics of health is the most adeguate metre or yardstick to measure such attitude. Infant mortality, care for the handicapped and the elderly, the average life expectancy are all indications that speak stronger than all the discourses of the dictators of the world.

Without world politics inspired by human values, sporadic achievements serve no purpose, even if in themselves they are excellent. In a Third World country, in which the dictatorial government professed to be Christian but did not hesitate to do away with political adversaries, there was—financed by the regime—an institution for the disabled, among the most successful in the world, that left visitors and specialists from other nations dumbfounded. It was a permanent display of the opposite of what existed in the nation.

Politics inspired by human, Christian values intends, in the first place, *health for all*. That which we see in general is the application of resources in inverse proportion to needs.

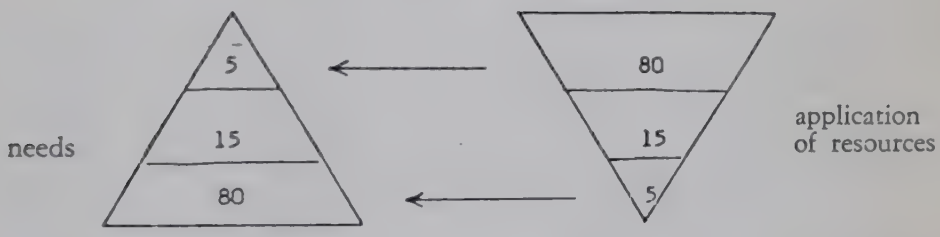
Above all in Third World countries the health needs can be demonstrated in this way:

— 80% need for primary care (ambulatory and dispensary);

— 15% need for secondary care (the fields of general care);

— 5% need for third level care (highly specialised fields of care).

Resources, on the contrary, are applied this way: 80% for third level care, and 5% for primary care, inverting in this way the pyramid of the needs of the people.



One can also say that in many countries doctors (perhaps also Catholic doctors) are more numerous where there is money than where there are sick people.

It is a shame that in many parts of the world people continue to suffer and die from diseases long ago conquered by science; that people continue to suffer and die for lack of food and medicines, when huge sums of economic resources are spent to make instruments of deaths, arms of every type, which arrive in abundance in countries of famine.

A country enters the path leading to human and Christian underdevelopment when partisan politics replaces the politics of the common good in the world of health. Places

of care for the ill become places of profit and political favoritism for the healthy. The notion of the purpose of health service is lost, and health care workers are admitted (or are sought)—workers with no vocation for this eminently human service, that requires intelligence and requires heart. In consequence there occur in hospitals things that are seen, and other things that are not seen.

Certainly there are other examples of the degradation of the service in the world of health, not the least of which is the miserliness with which prestigious governments pay hospital personnel and hospital administration, especially charitable hospitals.

These are some political aspects that make the mission of the Church and its health care institutions difficult; aspects which are enormously aggravated when political regimes are hostile to Christian religion, when laws are imposed which the health care worker in conscience cannot obey.

Sacramental dimension

Evangelisation is complete only when the life of faith, seen in love and in hope, is celebrated in the liturgy. This is as the summit toward which all pastoral action is directed, and at the same time constitutes its source of light and force.

A frequent temptation in the hospital field is to treat the sick as the faithful are treated who frequent our churches. If these faithful constitute 20% of the population, then 80% of the sick are among those who do not practice religion, and do not know what the sacraments are and what purpose they serve. Given the psychological situation of the sick, to offer is, in a certain way, to impose. Respect for the freedom of the sick person is the first attitude that opens his heart to the action of God.

In the celebration of the liturgy, then, two extremes must be avoided: trying to carry out a liturgy devised for the healthy, as if the sickroom were a cathedral; or else trivialising the sacramental gesture, emptying it of its community dimension.

Moreover, it must be kept in mind that places of care require a specialised preparation on the part of health care workers, that they be capable of understanding the situation, of comprehending the sick, and that they be creative.

Conclusion

The time at my disposal has run out. I would hope that what I have stressed may offer a beginning for a fruitful and creative dialogue, rich with indications of a new presence of the Church, full of hope, so that in the world of health, besides adding years to life, we try to add life to the years.

NEEDS OF THE CHURCH IN HEALTH CARE (LEGAL IMPLICATIONS)

RICHARD J. CONCANNON

Good afternoon, ladies and gentlemen. It is an honor and a privilege for me to be here today to share some thoughts with you about the legal implications of the Church's needs in its mission to care for the sick and the disabled. Obviously, you are an international audience; you come from many nations and the legal implications of your activities emerge from a wide variety of laws and customs. I would not pretend for a moment to possess expertise over such a broad legal field.

I come from the United States, from the City and State of New York. I therefore come from a religiously pluralistic society; a society heavily regulated by multiple layers of government, and a society that depends a great deal on government for the funding of health care. I am sure that each of you can point to differences in your situation, often profound differences, in the societal, regulatory and governmental climate within which you must function. But I also feel that the legal challenges we all confront in trying to deliver health care, consistent with those principles that bring us here today, have many things in common.

I will discuss some of them in a way that I hope reflects their universality.

I have listened with interest to the other speakers who have come before us. Although representing many professions and disciplines, and coming from many parts of the world, all focused on several matters that seem to raise

questions for all of us. I am a lawyer, and my focus will be on the law.

Of course, in any discussion involving law, we are ultimately talking about government: government in its legislative role, enacting laws; government in its executive role, carrying out and implementing laws through enforcement and regulation; and government in its judicial role, interpreting and applying laws. While for each of us, the impact of each component may be different, for all of us government is the legal universal.

So far as concerns lawmaking, we must acknowledge the strong influence of secularism. In the United States, for example, much legal decision making in the kinds of matters we are discussing this week flows from our courts. Our system provides for court constitutional review of laws enacted by both our federal and state legislatures. What began as an eighteenth century American constitutional protection against establishment of a national religion, and a guaranty of freedom of religious exercise, has been evolved by our courts into a rather strident twentieth century constitutional secularism. The result is that in the United States many decisions affecting matters of supreme importance to the Church are made ultimately by courts and judges and not by elected legislatures, and flow from an essentially secular reasoning process.

As we turn our attention to problems with moral dimensions that create concern and possibly threats to Church mission fulfillment, we must realize that those same problems usually present moral and ethical concerns to many other elements in society, both religious and secular. Their involvement in the lawmaking process can be helpful and supportive, or the source of additional opposition, or, most frequently, a mix of both supporting and opposing views.

In any case, when we add the conventional response of the political process to follow what it perceives to be the safest, if not the wisest, course, we begin to grasp the truly complex nature of the Church's difficulties in following its moral imperatives.

We must approach our tasks realistically, recognizing that we do exist in complex societies, with competing interests and views, both hostile and sympathetic, where all we do, and all we are unable to do, is affected by temporal law and all those factors that shape and decide it.

We profess beliefs that define a human being in a very particular way. Those beliefs determine for us much of what is right and appropriate in health care and much of what is wrong and unacceptable. We have a simple but profound belief in the obligation to honor and preserve human dignity in all we do. We do not accept and cannot accept the idea that patients represent economic units for doctors and hospitals, nor training aids for medical students. Doctors and hospitals exist to take care of patients, not the other way around.

But our beliefs extend as well to the complex and profound, so we find ourselves, along with learned theologians and others, wrestling with difficult moral questions confronting us, not only as a result of tragedies that have been with us a long time, such as abortion and euthanasia, but also with newer problems flowing from the continuing and rapid expansion of medical knowledge and technology, problems that become singularly compelling as the fruits of those scientific efforts become available to the public.

To mention just a few examples, medical science now provides the mechanical means to maintain a human body in cases where clinical indications are that, without mechanical support, all bodily activity would cease. In some cases, mechanical means are used to prolong the existence of what can only be realistically described as cadavers, human bodies in which all brain activity has totally and irreversibly ceased, bodies in which all cardio-pulmonary activity would cease as well within moments after withdrawal of mechanical support. In other cases, some neurological function exists, although this so-called vegetative state is permanently irreversible.

Is brain death, death? If it is, as appears to be the increasingly prevalent view—clinically, legally and morally—

then it would seem that simple human dignity dictates prompt removal of support systems.

Should mechanical means be used to support the existence of whatever life might be said to exist in one in an irreversible vegetative state? Most opinion leans to the view that to do so is an intrusion on the right to die with dignity. But, who should decide whether or when mechanical means of life support becomes unreasonable and morally unjustified? The State? An individual? And, if an individual, who should it be, and are not guidelines needed in any event?

Looming over both issues is the increasing success of organ transplantation—in fact, so much success in the case of certain organs that the emerging problem is one of organ shortage, rather than insurmountable medical hurdles in transplanting them.

I am sure we all know that the major source of viable organs is the trauma victim, brain dead from injury, but whose organs remain vital through mechanical maintenance of the body. Movement is towards consensual utilization of those organs to save lives, but under clear clinical controls.

In the case of the irreversibly vegetative individual, humane decisions to remove mechanical life support systems, to allow individuals to die with dignity, also reduce or removes the best clinical means for organ preservation.

The Church, in articulating and urging adherence to moral standards in the law as well as in practice, does so in the face of competing factors, such as the costliness of maintaining the hopelessly ill, the chronically vegetative, and, indeed, of maintaining brain dead bodies, all within the framework of a growing need for viable organs for transplantation. Consider if you will the question of whether we should mechanically maintain dead bodies indefinitely as an inventory source of organs. I assure you, that thought has been seriously advanced.

Another scientific gain provides us with the ability to preserve what in many cases can only be described as the existence of profoundly handicapped newborn babies. But

what means of doing so are reasonable? And when and for how long are they reasonable? And to preserve what kind of life? And who decides and who pays?

I made reference to competing factors. Pause for a moment over the factor raised by the question of "who pays?" I think it is safe to say that, regardless of whether we are speaking about local, national or world-wide conditions, we are confronted with finite resources. What proportion of those resources should be utilized for the provision of basic health care needs and what proportion should be utilized for the sophisticated treatments becoming available. And who gains access to available facilities capable of providing those sophisticated treatments? Only the rich? Again, government is acting on these questions, and the Church's concerns and references for the poor, and for the broad availability of basic health care, need to be reflected in that legal process, as well as urged as a moral commitment.

To move to what might be considered one of the outer limits of current medical scientific activity, we are all familiar with the publicity surrounding the successful utilization of in vitro fertilization to produce apparently healthy children to couples previously unable to achieve fertilization and uterine implantation. Of course there are very serious moral questions raised by the processes by which such happy results are brought about, but when one couples the prospect of genetic engineering with those processes, questions of alarming proportions arise. One need only reflect back to events occurring within the memories of most of us: the attempted coupling of brilliant scientific capability with maniacal racial notions presented the danger in its worst light. But, here again, a perceived good exists sufficient to many to address the question of whether laws can be drafted to control the dangers while developing the technology to achieve the benefits. The successful use of in vitro fertilization, frozen sperm, frozen embryos and genetic efforts to improve animals, has provided a ready source of information and experience. And, flowing from

continued research, experimentation and experience, is the confidence that congenital maladies in humans can be identified and corrected in the embryonic stage of life for implantation in the womb. And while in somatic cell therapy, non-reproductive cells are the subject of correction, which would result in non-inheritable genetic change, correction to germ cells would result in inheritable genetic changes. Cystic fibrosis and sickle cell anemia are just two of the genetic diseases that are viewed as within reach of genetic correction. We cannot minimize the benefits of effectively attacking these and many other genetic diseases at the beginning of life with consequent relief of human misery. But before letting this technology unleash itself, all of society has much to consider. Extensive dialogue has already taken place and continues; the outcome of the consideration of the issue is going to continue to present the Church with grave problems, not only in protecting itself and its institutions from encroachment on their right not to do that which they view as immoral, but also in providing moral leadership to society as it tries to cope with the moral issues in an atmosphere where dramatic benefits can flow from unacceptable means. Laws and regulations are coming into effect governing these matters, and the Church must continue to address their moral dimensions.

Yesterday we had a discussion of the question "what is a Catholic Hospital?" The most fundamental of questions. Yet, the legal dimension of that question thrusts upon us the need to assure both the Catholic identity of Church institutions and their adherence to the Church's mission in all they do. At a minimum, it dictates a need for legally enforceable lines of authority within a Catholic institution's organizational structure: we must preserve the nature and role of the institutions through which the Church fulfills its health care mission. As the complexity of the health care task has escalated, and as the demands of a growing population on a proportionately smaller clergy and religious has taken its toll, increasing reliance has had to be placed on the management and professional resources of the laity.

Organizational models have had to be developed, consistent with local laws, to assure the religious and philosophical thrust of the institution. In the United States, conventional corporate structures have proven adaptable to those Church needs. But, regardless of the particular structure utilized, it must provide legally appropriate means for response and protection of the institution's role in mission fulfillment, for without such means the very institutions upon which the Church relies could melt away in the heat of debate and discord over doctrine and mission destructive compromise.

I have referred to government as a source of the laws by which we live. It is an ever present and powerful force affecting the Church's health care mission, a force for good when it responsibly oversees and regulates the availability and quality of health care and when it shares in the cost of delivering that care. However, government regulation and control inevitably accompany government beneficence, and it is with the nature and extent of that involvement that conflicts and problems arise. When government funding is conditioned on the provision of medical services or activities that come into conflict with Church teaching, Catholic health care facilities, unable to comply with such conditions, often risk losing critically necessary funding covering a wide variety of services and procedures, not just those in conflict with Church teaching. To the extent government funding becomes crucial to the survival of our institutions, our ability to deal effectively with government becomes crucial. Unfortunately, financial resources are one of the most pervasive forces of all, one that might be called the ultimate temporal reality. With all of the spiritual resources at our disposal, with all of the human willingness to work and sacrifice, we still cannot avoid the impact of the need to meet the costs of what we want to accomplish.

Purposeful, hostile action by government presents the worst case, but not the only one. Bad law often comes into existence with only a pragmatic political motive, neither hostile nor friendly. Government action, whether or not threatening, flows from a process. We must generate and

maintain the capability to learn in advance of potentially destructive legislative or regulatory action. We must make every effort to deal fairly and effectively with government at every level, to assure that our views are heard and considered at every level. If the Church is going to defend spiritual values in the delivery of health care and look to government—as it should—for its fair share of financial support of health care, we must improve both our understanding of the legal processes by which laws are made and the effectiveness of our participation in those processes. Those with solely economic interests certainly do so, and I believe the preservation of moral values deserves a similar effort. Of course, legal challenges to the power of a legislating or regulating body to adopt measures damaging to the Church's mission must be made wherever and whenever appropriate.

I do not view government as an implacable enemy to the Church in its health care mission. There is no reason it needs to be an adversary: a shared desire by government and Church institutions to deliver high quality health care, consistent with sincerely held moral values, should be, and in my experience often is, the case. Even in cases of doctrinal conflict, resolution is possible. I can point to constructive and successful discussions with government where it recognized and respected deeply held religious views and accommodated them.

I presently serve on a committee appointed by the Governor of the State of New York—the Governor's task force on life and the law; it was formed to consider and make recommendations to the Governor on a wide range of difficult and pressing medical/legal issues. Currently on our agenda are such things as brain death, orders not to resuscitate, in vitro fertilization, genetic engineering, withdrawal of life support, care of the profoundly handicapped newborn and surrogate decision making. The task force is to remain in existence indefinitely. Its members include not only physicians and other health care professionals, and lawyers, but also clergy of many faiths, including Roman

Catholic priests. The task force is chaired by the state Commissioner of Health, a political appointee, who has been mentioned as a possible candidate for elective office. The Governor who appointed the task force is widely viewed as a strong contender for the presidency. In short, the task force can be viewed as a microcosm of the overall atmosphere within which are made the laws and regulations governing health care: well-intentioned, politically sophisticated government appointing and being involved in a committee of people experienced in health care delivery, but representing as well a wide variety of religious, philosophical and ethical views.

After many months of work, the task force is preparing for submission to the Governor proposed state legislation covering orders not to resuscitate and proposed state Health Department regulations covering brain death guidelines. The essential elements of the legislation and the regulations have been agreed upon in an atmosphere of analysis and understanding of religious and ethical views, as well as knowledge of the medical and legal aspects of the subjects. To this layman and to the priests on the task force, who have played active roles, the consensus thus far reached presents no problems for the Catholic health care community. No one can predict the outcome of future deliberations on other issues. But, the Church is there, it is participating, and that, in my judgment, is good. It is good because by active participation and involvement in the lawmaking processes, the Church provides an important voice for good, as well as helps to protect and preserve its health care mission at a level needed by people throughout the world.

In the conclusion, let me say that the legal implications of the needs of the Church in health care is a *very* broad topic—and a very important one. I have tried to do some justice to it in these few minutes. I have enjoyed sharing these thoughts with you and hope that you have found some of them of interest.

Dr. C. J. VAS
President FIAMC

Excellency Archbishop Angelini and fellow workers in the health sphere.

I bring cordial greetings from FIAMC, the French acronym for the International Federation of Catholic Medical Associations, which is a federation of national associations or guilds of Catholic doctors.

We had our initiation a long time ago in Paris as a result of the publication of the encyclical *Humanum Genus* in 1884 which exhorted doctors like other professionals to form guilds or associations. Since that time we have grown slowly and now have national associations in all 6 continents and also possibly, or hopefully, some vestige in the countries where the Church is silenced.

Our national associations are grouped into 6 regional or continental zones which meet every 4 years and all meet together in a world assembly also every 4 years but in a staggered way with the regional groups, i.e. we meet every 2 years.

The international executive committee includes 4 office bearers: President, Secretary General and Treasurer elected by a General Assembly and an Ecclesiastical Adviser appointed by the Holy See.

Apart from a fledgling Secretariat in Rome over the past 2 years to which we have come, we have a FIAMC Bio-Medical Ethics Centre established in Bombay in 1981,

which is growing well and appears to be a promising child. And now to turn to some reflections.

In recent years, the public mind has been alerted to the necessity and usefulness of preventive health care. Nonetheless, curative health care as provided by clinics and hospitals is still essential even though expensive. The existence of a vast member of Catholic Hospitals throughout the world does call for collaboration amongst them and co-ordination of their activities with other Catholic professionals working in the field of health . It is here that I, for one, appeal as strongly as possible for the creation or revival of an International Association of Catholic Hospitals.

Hospitals, inanimate as they seem, do not only consist of mortar, bricks, beds and pans but also individuals in diverse specialities, each with a special mission and responsibility. Fortunately over the years since the encouragement given by Pope Leo XIII in his encyclical *Humanum Genus* of 1884 which strongly advocated the formation of guilds and associations of workingmen and professionals, the majority of Catholic health workers have established their own independent national and international groups. Amongst these, there is now also a need for an international organisation of Catholic Hospitals and institutes of health. Such an association will take its rightful place amongst the international organs of Catholic professionals in health such as nurses, doctors, pharmacists and paramedical, all working unitedly but yet maintaining their own identity. The only difficulty is that the existing groups of health workers are "profession" oriented whereas the new Association of Catholic Hospitals would encompass all the groups of health care professionals in addition to administrators.

It is here that some prudence and caution must be exercised in the light of past experience. There should be as far as possible a clear demarcation in the aims and activities of an international association of Catholic Hospitals from those of other groups of health professionals. This is best exemplified at a national level where a Catholic

Hospital association may well undertake activities designed for the development of hospital "employees" such as nurses, doctors and others. In this way, the function of the professional associations of nurses, doctors and others may be duplicated or thwarted. Unfortunately, this has previously been known to occur in some countries. However, much will be gained in terms of activities and experiences by all these professional groups working in cooperation with each other while yet maintaining their own identity.

Please permit me at this stage to present some views in regard to what I would like to see in our Catholic Hospitals based on my personal involvement as a physician in urban, national and international activities and from the perspective of a doctor.

1. I feel strongly that Catholic Hospitals should preferentially involve Catholic doctors as much as possible in their work. In particular, I would like to see our institutions extend themselves to take up young specialist doctors even in excess of the staff strength as is often done by non-Catholic private hospitals in many countries. In this way, the young medical specialists are encouraged and a brain drain avoided in developing countries. Such a preferential selection would naturally be dependent on the young professionals being undoubtedly well trained and experienced in the specialities, with the ability to work harmoniously and cordially in the chosen institution. A sine qua non, to my mind, would be to live and work as a truly committed Christian with loyalty to magisterial authority.

2. Our Catholic Hospitals should encourage their staffs to keep abreast of the ever continuing advances in the medical field and to provide the benefits of such progress to patients under their care without "dehumanising" medical practice as often happens.

3. In the turmoil of caring for patients and medical practice today numerous problems arise in the minds of dedicated workers which raise issues of morals and ethics

involving institutions, doctors, nurses, patients and society at large. These matters are often not easy to deal with as is well known. I would, therefore suggest, if I may, that research and ethics committees be established in all our Catholic Hospitals with proper guidelines indicated for their functioning. The FIAMC Bio-Medical Ethics Centre at Bombay, as also other Ethics Centres, is committed to the study of this subject. This may well be one area where all the international Catholic health associations could come together to formulate the very necessary guidelines.

4. Please forgive me for bringing up yet another topic which concerns medical professionals greatly. As is well known, Catholics cannot involve themselves in procuring or performing abortions but young medical graduates wishing to specialise in obstetrics and gynaecology are not infrequently compelled to perform abortions while in training. Should such individuals refuse to perform abortions, as they should not and cannot, they are not accepted for training. This being so in both developing as well as advanced countries, one need not be a prophet to foresee a time when Catholic obstetricians and gynaecologists would be a rarity. Presumably, there will be a time when our huge number of 6,400 Catholic Hospitals in the world will probably be staffed more by non-Catholic specialists in this area then we would like to imagine. This situation will soon become a reality. I appeal as strongly as I can to all our Catholic institutions, our associations of professionals involved in health care, as well as to the Holy See to come together urgently to study and devise ways and means of dealing with this tremendous problem. Unfortunately, despite my many pleas over the past twelve months in many Catholic circles, nothing whatever has yet been done.

I conclude by expressing my gratitude to the Chairman, Mons. J. Cassidy, Secretary General Dr. M. Sacchetti and the members of the Steering Committee for their kindness in inviting me to attend this Congress. May your activities be blessed and result in the formation of the much needed International Association of Catholic Hospitals.